CDC FY 2009
Online Performance Appendix

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INTRODUCTION

The Online Performance Appendix is one of several documents that fulfill the Department of Health and Human Services' (HHS') performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through HHS agencies' FY 2009 Congressional Justifications and Online Performance Appendices, the Agency Financial Report and the HHS Performance Highlights. These documents can be found at: http://www.hhs.gov/budget/docbudget.htm and http://www.hhs.gov/afr/.

The Performance Highlights briefly summarizes key past and planned performance and financial information. The Agency Financial Report provides fiscal and high-level performance results. The FY 2009 Department's Congressional Justifications fully integrate HHS' FY 2007 Annual Performance Report and FY 2009 Annual Performance Plan into its various volumes. The Congressional Justifications are supplemented by the Online Performance Appendices. Where the Justifications focus on key performance measures and summarize program results, the Appendices provide performance information that is more detailed for all HHS measures.

The CDC Congressional Justification and Online Performance Appendix can be found at:

- http://www.cdc.gov/fmo/PDFs/FY09_CDC_CJ_Final.pdf
- http://www.cdc.gov/fmo/PDFs/FY09_CDC_Online_Performance_Appendix.pdf

SUMMARY OF MEASURES AND RESULTS

The table below provides a summary of CDC's performance measures.

SUMMARY OF MEASURES AND RESULTS							
FY	Total Targets	Results Reported		Targets			
		Number	%	Met	Not Met		% Met
					Total	Improved	
2004[1]	35	34	97%	21.03	12.97	0.14	62%
2005[1]	69	60	87%	42.03	17.97	6.83	70%
2006[1]	99	80	81%	58.17	21.83	6.42	73%
2007[1]	131	59.7	46%	47.67	12	4	80%
2008	136	N/A	N/A	N/A	N/A	N/A	N/A
2009	144	N/A	N/A	N/A	N/A	N/A	N/A

[1] FY 2004 – FY 2007 reflect the results of multiple targets for some measures within the performance plan.

PERFORMANCE DETAIL

INFECTIOUS DISEASES

IMMUNIZATION AND RESPIRATORY DISEASES

#	Efficiency Measure	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	FY 2010 Target
				Target	Actual	Target	Actual			
1.E.1	Make vaccine distribution more efficient and improve availability of vaccine inventory by reducing the number of vaccine inventory depots in the U.S. [E]	N/A	>400 (Met)	Award contract to centralize distribution, validate existing baseline	Yes (Met)	Reduce inventory depots by approximately 17%	36% reduction (Exceeded)	Reduce inventory depots by 50%	Reduce inventory depots by 98%	Maintain 98% reduction in inventory depots

Efficiency Measure 1.E.1:

The Section 317 grant program was among the first round of programs OMB reviewed with its PART tool unveiled with the FY 2004 budget submission. The review gave the 317 program high marks for its design, function, and success in achieving dramatic disease reduction though childhood vaccination. PART found that the program would be improved by a more specific mechanism to link successful outcomes to program processes and budgets. Subsequent to the PART review, the program initiated the vaccine management business improvement project (VMBIP) to revamp the entire vaccine distribution process and enhance the efficiency and accountability of vaccine management systems.

Once fully implemented, the new systems will automate and integrate vaccine ordering and management by centralizing distribution of all public purchased vaccines. The program has consistently met its targets by reducing the number of vaccine inventory depots in the U.S. As of October 2007, 34 of the 64 immunization program grantees have transitioned inventories to the centralized distributor and the number of depots has been reduced by 36 percent (from 396 depots to 253), thus exceeding the anticipated reduction target of 17 percent.

Efficiencies anticipated from consolidation of vaccine depots include improved management of vaccine inventory through use of distribution best practices and increased visibility of the location of vaccines throughout the pubic vaccine supply chain. These efficiencies will enhance CDC's ability to address public health emergencies such as vaccine shortages. Full implementation of this new vaccine purchase and distribution operating model is anticipated to gain additional efficiencies by reducing vaccine wastage and reducing inventory holding costs.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	FY 2010 Target
				Target	Actual	Target	Actual			
Long Term Objective 1.1: Reduce the number of indigenous cases of vaccine-preventable diseases.										
1.1.1	The number of indigenous cases of paralytic polio[1], rubella[1], measles[1], *Haemophilus influenzae* invasive disease (type b and unknown types) [2], diphtheria [3], congenital rubella syndrome [4, 5], and tetanus [3] will remain at or be reduced to 0 by 2010. [O]									
	- Paralytic Polio	0 (Met)	0 (Met)	0	0 (Met)	0	9/2008	0	0	0
	- Rubella	7 (Exceeded)	7 (Exceeded)	15	11 (Exceeded)	8	9/2008	8	5	0
	- Measles	10 (Exceeded)	42 (Exceeded)	50	24 (Exceeded)	45	9/2008	35	25	0
	- Haemophilus influenzae	196 b + unknown (Unmet)	226 b + unknown (Unmet)	150	208 b + unknown (Unmet)	150	9/2008	150	75	0
	- Diphtheria	0 (Exceeded)	0 (Exceeded)	5	0 (Exceeded)	4	9/2008	4	3	0
	- Congenital rubella Syndrome	0 (Exceeded)	0 (Exceeded)	5	0 (Exceeded)	4	9/2008	3	2	0
	- Tetanus	6 (Exceeded)	5 (Exceeded)	25	12 (Exceeded)	13	9/2008	10	8	0
1.1.2	Reduce the number of indigenous cases of mumps in persons of all ages from 666 (1998 baseline) to 0 by 2010. [O][5]	258 (Unmet)	314 (Unmet)	200	6,584 (Unmet)	200	9/2008	200	100	0
1.1.3	Reduce the number of indigenous cases of pertussis among children under 7 years of age. [O]	6,850 (Unmet)	7,347 (Unmet)	2,300	3,841 (Unmet)	2,300	9/2008	2,300	2,150	2000

[1]All ages.
[2]Children under five years of age
[3]Persons under 35 years of age.
[4]Children under one year of age. Result column indicates all cases – indigenous and imported. Imported cases will be differentiated in 2007, but those data are not yet available.
[5]Actual columns indicate all cases – indigenous and imported. Imported cases will be differentiated in 2007, but those data are not yet available.

Long Term Objective 1.1, Performance Measure 1:

Vaccination programs have made a major contribution to the elimination of many vaccine-preventable diseases and significantly reduced the incidence of others. National recommendations provide guidance for use of vaccine to prevent or eliminate 17 vaccine-preventable diseases. Nine of the 17 diseases currently vaccine-preventable are represented by this objective to reduce the incidence of indigenous cases of vaccine-preventable disease. The sub-objectives for Long Term Objective 1.1 correspond to many of the diseases prevented by vaccine coverage objectives tracked in Long Term Objective 1.2 which ensure that children age 19 to 35 months are appropriately vaccinated.

The ambitious 2010 targets for these sub-objectives are consistent with the Healthy People (HP) 2010 goals set prior to 2000. Some targets need to be reconsidered. For instance, tetanus is a non-infectious vaccine-preventable disease which is naturally occurring in the environment, thus a disease reduction goal of zero is not realistic, even with universal

vaccination. The process for developing goals and targets for HP 2020 is in its very early stages. This process will initiate extensive program-level consideration of objectives and corresponding targets for the next decade. In cases in which the program is consistently not meeting its targets, consideration is given for how targets can be set more appropriately through the HP 2020 process.

In 2006, 55 cases of measles were reported in the US. Thirty one of these 55 cases were classified as imported cases and 24 were classified as indigenous. The HP 2010 and GPRA goal is indigenous measles cases, therefore, in 2006, the goal of less than 50 cases was achieved. Reaching the 2010 goal of zero cases may be unlikely for multiple reasons: 1) measles is still endemic in many parts of the world; 2) no vaccine, including MMR, is 100 percent effective; and 3) some groups of persons in the U.S., including infants less than 12 months and persons with severe immunocompromising conditions, are not recommended for vaccination. Until measles is eliminated globally, there continues to be a risk of measles transmission to U.S. residents. CDC will continue to work with state health departments and immunization partners to ensure high routine 2-dose MMR coverage and MMR vaccination of selected high-risk groups as defined by the Advisory Committee on Immunization Practices (ACIP). CDC will also continue to be a major partner in the global measles elimination initiative. Given the continued risk of measles transmission in the U.S., CDC subject matter experts will consider the above mentioned issues when setting the HP 2020 goal for measles.

Haemophilus influenza type B (Hib) – Conjugate vaccines for the prevention of Hib are highly effective. Hib is no longer the leading cause of meningitis among children younger than five years old in the U.S. The number of possible cases reported increased from 196 cases in FY 2004 to 226 cases in FY 2005. However, the cases dropped in 2006 to 208 cases. Although from FY 2005 to FY 2006 cases decreased, the FY 2006 target of 150 cases remains unmet. In accordance with the HP 2010 goal, this measure includes both type B cases (for which vaccine would be effective) and those with unknown serotypes. The number of cases with unknown serotypes that are actually type B cannot be confirmed. Neither HP 2010 targets nor GPRA targets have been adjusted to account for cases with unknown serotype. Therefore, while this goal remains unmet, the actual number of type B cases (both serotyped and not) for which the vaccine would have been effective may have remained the same or even decreased. The increase in cases from FY 2004 to FY 2005 may be explained by these disease reporting challenges. To address this issue of incomplete serotyping, CDC is working with state partners to provide technical assistance for enhanced Hib surveillance and laboratory support. As the program sets forth goals for the next decade through the HP 2020 process, disease reduction targets and measures for Hib will be revisited to ensure that case confirmed Hib disease is distinguished more clearly from incidences of unknown serotypes.

Additionally, tetanus targets should be reviewed given that it is an environmental pathogen, a "0" target is likely not realistic.

Long Term Objective 1.1, Performance Measure 2:

The mumps disease targets were not met in FY 2006 due to a large national mumps outbreak that began in December 2005 and continued through FY 2006. Although the outbreak was concentrated in the Midwest, most states reported some increase in number of mumps cases. As a result of this outbreak, vaccination recommendations were modified in 2006 to better define evidence of immunity, ensure routine two-dose vaccination for high risk adult groups including college students and healthcare workers, and address additional vaccination needs for persons in outbreak settings.

Surveillance activities have also been enhanced to encourage reporting of all confirmed and probable mumps cases. Surveillance definitions for confirmed, probable and suspect mumps

cases were revised by the Council for State and Territorial Epidemiologists (CSTE), in collaboration with CDC, in 2007 and the new definitions went into effect on January 1, 2008. CDC is currently involved in studies to assess the level of protection from mumps from one and two doses of MMR vaccine to better understand why the 2006 outbreak occurred and use the information to prevent future outbreaks. CDC is also working to develop better laboratory tests to reliably diagnose mumps, especially in vaccinated persons.

Prior to FY 2004, there was some progress in mumps disease reduction - reflected by a two-thirds reduction in cases from FY 1998 (666 cases) to FY 2003 (231 cases). However, in FY 2004, the number of mumps cases increased to 258, thus CDC did not meet the disease reduction target of 200 cases for that year or for FY 2005. CDC is working to ensure that lessons learned from the 2005-2006 outbreak and specific enhancements in mumps prevention and control are fully applied to reverse the increase in disease cases. As a result of the outbreak, CDC will work with state health departments, and with laboratory, immunology and mumps disease subject matter experts to reassess the current HP 2010 target and determine if changes need to be made for the HP 2020 targets.

Long Term Objective 1.1, Performance Measure 3:

Pertussis (whooping cough) is a highly contagious, vaccine-preventable bacterial illness characterized by prolonged and severe cough and sometimes pneumonia. Although pertussis affects all age groups, complications and death are most frequently recognized among unvaccinated infants. The FY 2006 target was to reduce the number of pertussis cases among children under seven years of age to 2,300. The actual number of cases in this age group was 3,841. Although the target was unmet there was a 48 percent reduction in the number of cases in 2006 compared to 2005. Most of these cases occurred among children who are not fully protected from disease. Children are not fully protected until they receive four doses of the vaccine by 15-18 months of age. Many cases occur among infants who are exposed to disease before they receive their first vaccination at two months of age. Introduction in 2005 of adolescent and adult versions of improved acellular pertussis vaccines with tetanus and diphtheria booster (DTaP vaccine) provides new opportunities for reducing severe pertussis and its complications in all age groups in the U.S.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	FY 2010 Target
				Target	Actual	Target	Actual			
Long Term Objective 1.2: Ensure that children and adolescents are appropriately vaccinated.										
1.2.1	Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for: -4 doses DTaP vaccine[1] -3 doses Hib vaccine -1 dose MMR vaccine[2] -3 doses hepatitis B vaccine -3 doses polio vaccine -1 dose varicella vaccine -4 doses pneumococcal conjugate vaccine (PCV7)[3]	DTaP 86%; Hib 94%; MMR 93%; Hepatitis B 92%; Polio 92%; Varicella 88% (Exceeded, with the exception of DTaP and Varicella)	DTaP 86%; Hib 94%; MMR 92%; Hepatitis B 93%; Polio 92%; Varicella 88% (Exceeded, with the exception of DTaP and Varicella)	At least 90% cover-age	DTaP 85%; Hib 93%; MMR 92%; Hepatitis B 93%; Polio 93%; Varicella 89%; PCV7 68% (Exceeded, with the exception of DTaP and Varicella)	At least 90% cover-age	9/2008	At least 90% cover-age	At least 90% cover-age	At least 90% cover-age
1.2.2	Achieve or sustain immunization coverage of at least 90% in adolescents 13 to 15 years of age for: - 1 dose of Td containing vaccine [4]	N/A	N/A	Base-line	56.7%	90% cover-age	9/2008	90% cover-age	90% cover-age	90% cover-age

[1]Due to a shortage in vaccine and temporary change in recommendations, 3 doses were reported from 2002 – 2003.
[2]Includes any measles-containing vaccine.
[3]Performance targets for any newly recommended vaccines are reported in GPRA five years after an ACIP recommendation is made and once NIS data become available. The timing of data availability may also be impacted by the age group for which that particular vaccine is recommended or unanticipated vaccine supply disruptions.
[4] Includes one dose of Td or Tdap vaccine received at age 10 years or older. Two new Tdap vaccines were licensed in spring 2005 for use in adolescents.

Long Term Objective 1.2, Performance Measure 1:

The ACIP Recommended Childhood and Adolescent Immunization Schedule recommends routine vaccination of children for the above diseases. As childhood immunization coverage rates increase, cases of vaccine-preventable diseases decline significantly.

The nation's childhood immunization coverage rates are at record high levels for most vaccines.

- The 90 percent coverage target has been exceeded for four of the seven routinely recommended childhood vaccines (Hib, MMR, hepatitis B and polio) and has almost reached the 90 percent target for varicella (currently at 89 percent).
- Vaccination coverage rates for existing vaccines are high, but each year a new cohort of children are born and the program must make the same efforts to assure the vaccination of these children as was needed with the preceding cohorts. The 90 percent coverage goal is ambitious because as new vaccines are added to the childhood immunization schedule sustaining 90 percent vaccination coverage with vaccines recommended for

some time while trying to achieving 90 percent coverage with vaccines recently recommended becomes increasingly difficult.

- Nearly one million two-year olds in the U.S. have not received one or more of the recommended vaccines. Even though coverage levels for immunized children by age two are high nationally, and in many states, pockets of need, or areas within each state and major city where substantial numbers of under-immunized children reside, continue to exist.

The target of 90 percent coverage was met in FY 2006 for most vaccines with the exception of varicella, PCV7, and the fourth dose of DTaP.

- Varicella vaccination coverage has almost reached the 90 percent target; rates have risen from 43 percent in FY 1998 to 89 percent in FY 2006. CDC/HHS and the ACIP recently made policy changes for the use of varicella (chickenpox) vaccine to include a recommendation for routine two-dose varicella vaccination of children over 12 months of age. This new recommendation is expected to further reduce the number of cases and outbreaks of varicella in the U.S.
- The prevention of pneumococcal infections with PCV7 is becoming more important because of problems with treatment due to antibiotic resistance. The ACIP added PCV7 to the 2001 Recommended Childhood Immunization Schedule. Vaccination coverage with four doses of PCV7 is reported for the first time in 2006 because performance targets for any newly recommended vaccines are reported in GPRA five years after an ACIP recommendation is made and once data from the National Immunization Survey become available. Because the recommendation is so new, the rates in the first reporting year are below the 90 percent target at 68 percent. Coverage with three doses PCV7 has been rising; in 2006, 3-dose PCV7 coverage climbed to 87 percent from 83 percent in 2005. Please refer to the detailed discussion of PCV7 in the narrative for Long Term Objective 1.4, Performance Measure 1, regarding reduction of pneumococcal disease rates in children and older adults.
- Reaching 90 percent coverage for the fourth dose of the DTaP vaccine has been a struggle for a number of years. In FY 2006, the coverage rate for four doses of DTaP vaccine was 85 percent. This goal continues to be difficult to achieve because it requires that the fourth dose be given to the child between 15 and 18 months of age. The administration of DTaP tends to coincide with regular well-baby visits through the third dose; however, the fourth dose does not, requiring a visit specifically for this purpose. Coverage rates are 96 percent for the first three DTaP doses, but there is a drop-off for the fourth dose.

To sustain current high coverage rates and increase coverage rates for vaccines that have not yet reached the 90 percent target, CDC provides funding, guidance, and technical assistance to state and local immunization programs so that they may conduct provider assessments, develop and utilize immunization information systems, utilize coverage assessment information from the National Immunization Survey, and provide education and training to both public and private immunization providers.

Long Term Objective 1.2, Performance Measure 2:

New vaccine recommendations warrant the addition of an adolescent component to the longstanding childhood immunization goal as fully vaccinating a child now extends to the adolescent years. Beginning in 2005 and 2006, 11 and 12 year olds are recommended to receive three vaccines (tetanus, diphtheria, acellular pertussis [Tdap], meningococcal conjugate [MCV], and human papillomavirus [HPV] vaccines). Initially, the program is only reporting

performance for Td containing vaccine; however, performance for MCV and HPV will be reported in the near future. Td-containing vaccines have been recommended for routine use among adolescents for well over five years. This newly formulated booster vaccine Tdap is a replacement vaccine rather than a newly recommended vaccine.

Consistent with the corresponding childhood measure in this goal, performance for newly recommended adolescent vaccines will be reported in GPRA five years after ACIP recommends the vaccine and data becomes available. The performance reporting delay occurs because it takes time for the public and private sector immunization infrastructure to adjust to ensure program components are in place to implement the recommendation and assess vaccination coverage. Also, new vaccine implementation is dependent upon state-level policy decisions that impact which vaccines will be available through the Section 317 immunization program at public health clinics.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	FY 2010 Target
				Target	Actual	Target	Actual			
Long Term Objective 1.3: Increase the proportion of adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease.										
1.3.1	Increase the rate of influenza and pneumococcal vaccination in persons 65 years of age and older to 90% by 2010.	Influenza 65% (Unmet); pneumococcal 57% (Unmet)	Influenza 59.6% (Unmet); pneumococcal 56.2% (Unmet)	Influenza 74%; pneumococcal 69%	Influenza 69% (Unmet) Pneumococcal 63% (Unmet)	Influenza 74%; pneumococcal 69%	1/2009	Influenza 85%; pneumococcal 80%	Influenza 85%; pneumococcal 80%	Influenza 90%; pneumococcal 90%
1.3.2	Increase the rate of influenza and pneumococcal vaccination among non-institutionalized high-risk adults aged 18 to 64 years to 60% by 2010.	Influenza 35% (Met); pneumococcal 21% (Unmet)	Influenza 25.3% (Unmet) pneumococcal 22.6% (Met)	Influenza 32%; pneumococcal 22%	Influenza 34% (Met) Pneumococcal 23% (Met)	Influenza 32%; pneumococcal 22%	1/2009	Influenza 40%; pneumococcal 35%	Influenza 40%; Pneumococcal 35%	Influenza 60%; Pneumococcal 60%

Long Term Objective 1.3, Performance Measure 1:

During the past decade, vaccination coverage levels among older adults increased steadily as CDC implemented national strategies and promoted adult and adolescent immunization among healthcare providers and state and local governments. Influenza vaccination coverage levels among the elderly have increased from 30 percent in 1989 to 69 percent in the second quarter of 2007. Although for some time data suggested that influenza vaccination levels may have reached a plateau, the increase of coverage to 69 percent from 60 percent in 2005 is encouraging. The decrease in vaccination coverage in 2005 was most likely related to unprecedented shortages of influenza vaccination in the 2004-2005 season and delays of influenza vaccinations in the 2005-2006 seasons.

Despite recent vaccine availability issues, the increase in vaccination coverage began to slow before 2000. The plateau is not fully understood. Because large gaps remain between existing coverage levels and some of the targets for subsequent years, CDC decided to maintain an influenza vaccination target of 74 percent for FY 2005 to FY 2007. The FY 2008 President's Budget Request included additional funds to increase demand for influenza vaccine. Therefore, CDC increased the target in FY 2008 to 85 percent coverage for influenza vaccination, which

will continue into FY 2009. The FY 2010 target of 90 percent is consistent with the HP 2010 target set prior to 2000.

It is anticipated that influenza vaccine supply will continue to increase in upcoming years; as many as 132 million doses of vaccine could be produced by the end of the 2007-2008 influenza season. CDC and partners such as the National Influenza Vaccine Summit will continue to aggressively promote vaccination. Health care provider recommendations for vaccination are very influential in an adult's decision to receive influenza vaccine. CDC, along with the National Influenza Vaccine Summit, will target educational and communication efforts to health care providers. These efforts will include encouraging healthcare providers to recommend influenza vaccine to their patients and encouraging vaccination of healthcare providers, a recommended group with consistently low vaccine coverage. Efforts will also be focused on eliminating disparities in coverage.

The percentage of adults aged 65 years and over who had ever received a pneumococcal vaccination increased from 42 percent in 1997 to 56 percent in 2005. By 2006 the percentage of adults aged 65 years and older who had ever received pneumococcal vaccination was 63 percent. Adult vaccinations have been gradually increasing slowly. Recently there have been more dramatic increases in adult vaccination coverage occurring among adults age 65 and older. In 2006, there was a 10 percent increase in annual influenza coverage among adults 65 years and older and a seven percent increase in pneumococcal vaccination coverage. CDC has worked with the Centers for Medicaid and Medicare Services to raise the reimbursement rate for influenza and pneumococcal vaccines. Similar challenges apply to pneumococcal vaccination in adults as for influenza vaccination. Because large gaps remain between existing coverage levels and some of the targets for subsequent years, CDC decided to maintain the same targets for FY 2005, 2006 and 2007 for pneumococcal vaccination in this age group. However, due to an anticipated increase in aggressive vaccine promotion efforts, CDC raised the FY 2008 goal to 80 percent, which will continue into FY 2009. The FY 2010 target of 90 percent is consistent with the HP 2010 target set prior to 2000.

Long Term Objective 1.3, Performance Measure 2:

The ACIP Recommended Adult Immunization Schedule recommends vaccination for influenza for adults at high risk of complications each year and pneumococcal vaccination for those persons at high risk. Current levels of coverage among adults vary widely among different age, risk, and racial and ethnic groups. High-risk adults aged 18 to 64 years may not have insurance coverage for influenza and pneumococcal vaccines, may make fewer visits for preventive care, and may not recognize influenza and pneumococcal vaccination recommendations. Persons with high-risk conditions, such as heart disease and diabetes, remain at increased risk from these diseases.

The 2006 estimated influenza vaccination coverage for persons 18-49 years and 50-64 years with high-risk conditions was 25 percent and 44 percent, respectively. Although less than the HP 2010 objective of 60 percent, the coverage did increase from the 2005 estimates of 18 percent and 34 percent for those aged 18-49 years and 50-64 years, respectively. To reverse the downward trend in adult influenza observed between FY 2004 and FY 2005, CDC has been working with partner groups to increase awareness of influenza and pneumococcal vaccination recommendations among healthcare providers and the public.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	FY 2010 Target
				Target	Actual	Target	Actual			
Long Term Objective 1.4: Protect Americans from infectious disease – pneumococcal.										
1.4.1	By 2010, reduce the rates of invasive pneumococcal disease in children under 5 years of age to 46 per 100,000 and in adults aged 65 years and older to 42 per 100,000. [O]									
	- Children under 5 years of age	N/A	21.3 (Exceeded)	48	20.8 (Exceeded)	47	6/2008	46	46	46
	- Adults 65 years and older	N/A	38.8 (Exceeded)	47	40.5 (Exceeded)	45	6/2008	42	42	42

Long Term Objective 1.4, Performance Measure 1:

These data indicate that CDC is on track to reach disease reduction targets. Progress is aided by the introduction of the pneumococcal conjugate vaccine that was licensed for use in children in the U.S. in 2000. Vaccinating children has reduced disease in adults through reduced transmission. However, some challenges remain. Supplies of the conjugate vaccine were inadequate between 2001 and 2004. CDC has worked with the vaccine manufacturer, ACIP, and professional organizations to promote optimal and equitable use of vaccine during times of shortage. Vaccine supply is now adequate. However, a small increase in disease caused by strains not covered by the pneumococcal conjugate vaccine has been detected, and CDC is monitoring trends in these strains. Pneumococcal conjugate vaccine (PCV7) is the most recently recommended vaccine for which performance is reported.

New vaccines present special challenges to monitoring efforts. Although the information available during prelicensure characterizes immune response, clinical protection, and safety, the experience with a new vaccine prelicensure cannot substitute for strong postlicensure data. Postlicensure vaccination addresses much larger populations and high risk groups often excluded from clinical trials, and incorporates the practical realities of immunization delivery.

Prelicensure, PCV7 was known to be highly efficacious among fully vaccinated infants in protecting against invasive pneumococcal disease caused by vaccine-types. At the same time, the immunization program faced several challenges for the implementation of this vaccine.

- This vaccine was considered expensive at the time of introduction, and incorporating it into the childhood schedule effectively doubled the cost of routine infant and childhood immunization.
- Soon after routine recommendations were issued, PCV7 supply was inadequate to meet pediatrician demand, and interim recommendations for the use of vaccine according to partial schedules were issued.

Active surveillance for invasive pneumococcal disease, carried out by the CDC's Active Bacterial Core surveillance (ABCs) of the Emerging Infections Program Network, demonstrated dramatic declines in disease in the target age group as well as in the elderly and other adults beyond the target age group. Even without completing the full series of immunizations, high efficacy against invasive disease was achieved and the indirect or herd protection afforded by the vaccine was substantial. For every case prevented through direct vaccination, at least two additional cases of invasive pneumococcal disease were prevented among those who were not themselves immunized.

Vaccine introduction reduced racial disparities in invasive pneumococcal disease and reduced the incidence and prevalence of drug resistant pneumococcal infections in the general population. PCV7 introduction was associated with a 40 percent drop in total pneumonia hospitalizations among children, an impact much greater than could be anticipated from the prelicensure studies. Studies demonstrated that the full benefits and cost-effectiveness of PCV-7 greatly exceeded those estimated at the time national recommendations were promulgated in 2000.

Additional surveillance carried out by the CDC's Arctic Investigation Program suggested the emergence of replacement serotypes (serotypes not included in the PCV7 vaccine) in invasive disease among the target population of Alaska Native children. Unlike replacement seen in the general pediatric population in either Alaska or other U.S. populations, the magnitude of replacement disease among Alaska Native children was substantial and limited the benefits of PCV7 vaccination in this high risk group. These trends may herald important occurrences in other populations, or may be temporal fluctuations.

Strong and continued evaluation systems are needed to understand the need for new vaccine formulations and/or adjustments in immunization recommendations. Similar comprehensive evaluation of vaccine impact and uptake will be needed for the new vaccines.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 1.5: Improve vaccine safety surveillance.										
1.5.1	Improve capacity to conduct immunization safety studies by increasing the total population of managed care organization members from which the Vaccine Safety Datalink (VSD) data are derived annually to 13 million by 2010.	7.5 million (Unmet)	9.0 million (Unmet)	10 million	9.0 million (Unmet)	10 million	6/2008	10 million	10 million	N/A

Long Term Objective 1.5, Performance Measure 1:

Vaccine Safety Datalinks (VSD) is a collaborative effort involving CDC and eight managed care organizations: Group Health Cooperative Center (Seattle, Washington), Harvard Pilgrim Health Care (Boston, Massachusetts), Healthpartners Research Foundation (Minneapolis, Minnesota), Kaiser Permanente Colorado (Denver, Colorado), Kaiser Permanente Northwest (Portland, Oregon), Marshfield Clinic Research Foundation (Marshfield, Wisconsin), Northern California Kaiser Permanente (Oakland, California), and Southern California Kaiser Permanente Health Care Plan (Los Angeles, California). The VSD provides comprehensive medical and immunization histories for more than 5.5 million people annually, which are derived from the participating managed care organizations that contain more than nine million members.

The VSD was established primarily to assess immunization safety issues in the U.S. by conducting scientific studies utilizing large-linked databases that incorporate administrative data sources as each site and additional site resources such as medical charts. VSD has demonstrated associations between intussusception following Rotashield vaccination and the risk of seizures following Measles, Mumps, Rubella (MMR) or whole-cell pertussis vaccine. VSD developed a rapid sequential monitoring system that is being used to study vaccine safety concerns about RotaTeq vaccine and intussusception, Menactra (meningococcal conjugate vaccine) and Guillain-Barre syndrome, and the safety of Gardasil (HPV).

The performance target for this goal was not met in FY 2006 because increasing populations in LLDs is contingent on cooperating entities, resources, and technologies. Expanding the VSD population to collect adult data at all participating sites and expanding the number of participating managed care organizations are two strategies that will enable VSD to increase the percentage of the U.S. population represented in VSD and reach the performance target. During the FY 2010 budget and performance processes, this performance target will be re-evaluated and possibly changed.

PANDEMIC INFLUENZA

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 1.6: Protect Americans from infectious diseases – Influenza.										
1.6.1	By 2010, enhance preparedness for pandemic influenza by establishing influenza networks globally through bilateral cooperative agreements that are actively producing usable samples for testing as measured by geographic and population coverage.	9 networks; 1 with 100% geographic coverage; 70% population coverage; 8 with 10-40% geographic coverage and 10-40% population coverage per county network	12 (Exceed-ed)	9 net-works	13 (Exceeded)	20 net-works	30 (Exceeded)	30 net-works	30 net-works	N/A

Long Term Objective 1.6, Performance Measure 1:

This measure tracks CDC's efforts to increase the number of influenza networks globally to enhance early detection of viruses with pandemic potential and improve vaccine decision-making for seasonal influenza vaccine strain selection. Early detection of pandemic viruses will benefit the international community by allowing the maximum lead time possible to develop pandemic vaccines, initiate mitigation efforts early, and monitor the effectiveness of influenza antiviral medications, thus reducing morbidity and mortality globally. In collaboration with foreign ministries of health, CDC is supporting the development of sentinel surveillance systems for influenza including severe respiratory disease in over 35 countries.

By consistently exceeding the current performance measure over the past three years, CDC has established the influenza surveillance foundation necessary to conduct influenza burden studies, formulate vaccine policy and antiviral guidelines in the U.S., and reduce illness due to influenza. In FY 2007, internationally, CDC distributed close to $72,000,000 to over 40 countries and World Health Organization headquarters and Regional Offices along with technical assistance to develop capacity and support development of pandemic plans; improved epidemiologic investigation and response capacity; laboratory infrastructure and testing for avian, seasonal, and potentially pandemic influenza viruses; training; and risk communications.

Because targets have been consistently achieved and the number of networks will be maintained, CDC would like to retire this measure in subsequent years. The current measure is no longer appropriate or relevant. CDC will provide baseline information for a new measure(s) during FY 2008. CDC will use a new target-setting methodology to better align its targets for the new measure(s) in the future with associated timelines. Future target setting methodology will be linked to organization and reporting of influenza activities under six overarching goals: 1) increase the use and development of interventions known to prevent influenza illness in humans; 2) decrease the time needed to detect and report cases of influenza virus infection with pandemic potential; 3) improve the timeliness and accuracy of communications regarding seasonal, avian, and pandemic influenza; 4) decrease the time to effectively identify causes,

risk factors, and appropriate interventions for seasonal, avian, and pandemic influenza; 5) decrease the time needed to provide countermeasures for seasonal, avian, and pandemic influenza; and 6) decrease the time needed to restore health services and environmental safety to pre-event levels.

HIV/AIDS, VIRAL HEPATITIS, STD, AND TB PREVENTION

The domestic programs of the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) underwent a PART review for 2007 in preparation for the FY 2009 President's Budget. Previously, Domestic HIV/AIDS had been reviewed in 2002 and STD/TB in 2004. Viral Hepatitis was reviewed as part of the Infectious Diseases PART which also occurred in 2004. As a result of the review, existing GPRA and PART measures have been retired and replaced with a new performance plan consisting of new goals and measures negotiated through the 2007 PART process.

#	Efficiency Measure	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
2.E.1	Increase the efficiency of core HIV/AIDS surveillance as measured by the cost per estimated case of HIV/AIDS diagnosed each year.	$807	$887	$940	6/2008	$870	12/2008	$840	$775	N/A

Efficiency Measure 2.E.1:

CDC supports HIV/AIDS surveillance in collaboration with state and territorial health departments as a key component of its HIV prevention efforts. HIV/AIDS case surveillance data provide information on what populations are most affected by HIV/AIDS and are used to guide prevention, treatment and support programs at the local, state, and national levels. This measure reflects efficiencies that are being achieved in HIV surveillance nationally. While differing methods of HIV case surveillance have been implemented in different states, CDC recommends confidential, name based surveillance of HIV infection as the best means of providing accurate, reliable and unduplicated data. To monitor trends in the epidemic at a national level, CDC can only analyze data from states with mature, confidential, name-based HIV reporting systems. The number of states included in this analysis has risen over the years as additional states adopt confidential, name based HIV reporting methods, and as those systems are implemented and stabilize. Because CDC provides technical and financial support to HIV and AIDS reporting systems regardless of the type of reporting used, funds allocated to states to conduct core case surveillance are not anticipated to rise dramatically with the adoption and maturation of confidential, name-based surveillance in more states. Additional efficiencies might also be achieved as surveillance systems work with existing resources to accommodate increased reports of HIV resulting from widespread implementation of HIV screening.

DOMESTIC HIV/AIDS PREVENTION

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	FY 2015 Target
				Target	Actual	Target	Actual			
Long term Objective 2.1: Decrease the annual HIV incidence rate.										
2.1.1	Decrease the annual HIV incidence. [O]	N/A	6/2008	N/A	3/2009	N/A	3/2010	TBD	TBD	TBD
2.1.2	Decrease the number of pediatric AIDS cases. [O]	47	68	<100	3/2008	<100	11/2008	<75	<75	N/A
2.1.3	Reduce the black:white rate ratio of HIV/AIDS diagnoses.[1] [O]	9.09:1	8.71:1	8.7:1	3/2008	8.4:1	11/2008	8.4:1	8.2:1	N/A
2.1.4	Reduce the Hispanic:white rate ratio of HIV/AIDS diagnoses.[1] [O]	3.6:1	3.5:1	3.5:1	3/2008	3.4:1	11/2008	3.4:1	3.3:1	N/A
2.1.5	Increase the number of states with mature, name-based HIV surveillance systems.[1]	33	33	33	33	34	3/2008	35	37	N/A
2.1.6	Increase the percentage of HIV prevention program grantees using Program Evaluation and Monitoring System (PEMS) to monitor program implementation.	N/A	N/A	Baseline	0	20%	11/2008	45%	65%	80%
2.1.7	Increase the number of evidence-based prevention interventions that are packaged and available for use in the field by prevention program grantees.	11	14	N/A	14	15	11/2008	18	21	N/A
2.1.8	Increase the number of agencies trained each year to implement Diffusion of Effective Behavior Interventions (DEBIs).	1,068	1,114	N/A	987	1,100	2/2008	1,100	1,100	N/A

[1]As measured in the 33 states with mature, confidential, name-based HIV reporting in 2005. These are Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

Long Term Objective 2.1, Performance Measure 1:

This measure serves as both a long-term and annual PART measure. The measure addresses adults and adolescents (more than 13 years of age). The ability to monitor trends in new HIV infections (i.e., HIV incidence) is a fundamental indicator of the impact of HIV prevention activities in the U.S. However, until this time, CDC has not had the ability to monitor trends in HIV incidence.

CDC previously used several proxies to monitor trends in the epidemic. AIDS case surveillance was used until the late 1990s to monitor trends in the epidemic; however, the advent of effective, life-prolonging treatments has rendered AIDS surveillance less useful in monitoring trends in HIV infection. More recently, CDC has used HIV transmission among persons less than 25 years old as a proxy for HIV incidence, since most HIV infections among persons less than 25 years old are recent. However, since an estimated one quarter of HIV infections are currently undiagnosed, this measure is subject to confounding with changes in HIV testing behaviors. Initiatives to increase HIV testing are designed to increase the proportion of HIV infections that are diagnosed. If incidence remains stable, increasing the proportion of

infections that are diagnosed will result in increases in total diagnoses. Because such testing initiatives are currently being funded by CDC, new HIV diagnoses among persons less than 25 years old may be an inadequate proxy for HIV incidence.

CDC is now using newly available laboratory methods in a national HIV incidence surveillance system. CDC provides funding and technical assistance to selected state and local health departments to conduct HIV incidence surveillance. This complex surveillance system uses the Serologic Testing Algorithm for Recent HIV Seroconversion (STARHS) methodology, a testing algorithm developed by CDC staff to assess HIV incidence. Residual serum specimens from diagnostic HIV antibody testing are tested with a second test, the BED-HIV-1 Capture Enzyme Immunoassay (BED Assay). The BED assay measures levels of a particular antibody (immunoglobulin G) in the blood. At the early stages of HIV infection this antibody exists at relatively low levels, and the BED assay results are used to classify specimens as recent (incident) or long-standing infections. Ongoing population-based data from the funded areas are adjusted to impute annual national HIV incidence estimates. The first data from this new surveillance system will be available in mid-2008.

Long Term Objective 2.1, Performance Measure 2:

This measure addresses children less than 13 years of age who have developed AIDS. Among this population, AIDS has declined from nearly 1,000 cases per year in the early 1990s to 68 in 2005. This decline was strongly associated with increased HIV testing and treatment of infected pregnant women. Effective treatments for pregnant women have been shown to greatly reduce, but not eliminate, perinatal transmission (transmission can be reduced from an estimated 25 percent to less than two percent among HIV-infected women). More recently, some decline is likely associated with improved treatments which delay the onset of AIDS for HIV-infected children.

Prevention programs for this age group have been extraordinarily successful and further declines are contingent upon continued delay of development of AIDS among those children under 13 who are already infected; reductions in the perinatal transmission rate among pregnant women; and reductions in the prevalence of HIV infection among women. Given the growing population of women living with HIV and the existing number of children who are already infected, decreases in the number of children developing AIDS are unlikely. To achieve its target of fewer than 75 pediatric AIDS cases, CDC provides funding and technical assistance to 65 state and local health departments to conduct HIV/AIDS prevention programs, including perinatal transmission prevention. CDC also provides guidelines, technical assistance, and provider education to reduce perinatal HIV. Data for FY 2006 will be available in March 2008.

Long Term Objective 2.1, Performance Measure 3:

This measure compares the HIV/AIDS rates per 100,000 population between African Americans and whites in the 33 states with mature, confidential, name-based HIV reporting. The rate ratio between African Americans and whites has declined from 10.3:1 in 2002 to 8.7:1 in 2005. CDC provides funding and technical assistance to 65 state and local health departments to conduct HIV/AIDS prevention programs, including evidence-based prevention interventions for African American communities. CDC also provides guidelines, technical assistance, and provider education to reduce racial and ethnic disparities in HIV/AIDS rates. With this continued emphasis, CDC expects to continue to make steady progress in reducing this disparity. Data for FY 2006 will be available in March 2008.

Long Term Objective 2.1, Performance Measure 4:

This measure compares the HIV/AIDS rates per 100,000 population between Hispanics and whites in the 33 states with mature, confidential, name-based HIV reporting. The rate ratio between Hispanics and whites has declined from 4.1:1 in FY 2002 to 3.5:1 in FY 2005. CDC provides funding and technical assistance to 65 state and local health departments to conduct HIV/AIDS prevention programs, including evidence-based prevention interventions for Hispanic communities. CDC also produces guidelines, provides technical assistance, and provider education to reduce racial and ethnic disparities in HIV/AIDS rates. With this continued emphasis, CDC expects to continue to make steady progress in reducing this disparity. Data for 2006 will be available in March 2008.

Long Term Objective 2.1, Performance Measure 5:

This measure addresses the HIV surveillance systems in the 50 states. Since 1985, all states and territories have conducted AIDS surveillance using the same standardized name-based methods as all other infectious diseases. Implementation of HIV surveillance has been less consistently implemented, and some states have used code-based methods of HIV surveillance.

Based on CDC recommendations and requirements in the Ryan White Treatment Modernization Act of 2006, more states have adopted name-based HIV surveillance systems. However, after a state implements name-based HIV surveillance, it takes a number of years for the system to "mature" (establish statewide surveillance standards, train reporting entities, eliminate backlogs of prevalent cases, eliminate interstate and intrastate duplicates, etc.). For purposes of conducting statistical analyses of trends, etc., CDC does not include data from states until the HIV surveillance system is identified as being "mature." In CY 2006, 33 states had mature, confidential, name-based HIV reporting and will be included in the 2006 surveillance report. CDC expects this number to increase slowly in the coming years.

Data Availability – All annual measures based on HIV/AIDS surveillance data were expected in November 2007 but will be delayed until March 2008 due to a one-time delay in generating the 2006 HIV/AIDS Surveillance Report. There are three key reasons for this delay.

A one-time transition to the National Data Processing Initiative (NDPI), a new data collection and processing system for HIV/AIDS surveillance. This transition is both technically challenging and labor intensive, and has resulted in delays of some data outputs and analyses of 2006 HIV/AIDS surveillance data.

In June 2007, CDC issued a revised HIV/AIDS Surveillance Report for 2005 to correct for an error in the computer code used to statistically adjust the 2005 HIV/AIDS surveillance data. Regeneration of the 2005 HIV/AIDS Surveillance Report delayed preparation of the 2006 HIV/AIDS Surveillance Report.

The team that produces the surveillance report also provides intensive assistance to help states transition to name reporting as recommended by CDC and required for funding by the Ryan White HIV/AIDS Treatment Modernization Act.

Long Term Objective 2.1, Performance Measure 6:

This measure addresses use by HIV prevention program grantees of the Program Evaluation and Monitoring System (PEMS). CDC developed PEMS to strengthen monitoring and evaluation of HIV prevention programs nationwide. PEMS is a secure Internet browser-based software program for data entry and reporting and is to be used by health departments and CBOs funded through CDC HIV prevention cooperative agreements. Currently, more than 1,250 agencies, including health departments and community-based organizations (CBOs) across the country have access to PEMS. When fully implemented, PEMS will be used by all

health departments and CBOs funded through CDC HIV prevention cooperative agreements and will provide quantitative data to show program progress toward meeting implementation goals and program effectiveness.

In October 2007, CDC hosted a meeting of approximately 30 health departments and 15 CBOs to review technical issues of PEMS implementation and collection of data for monitoring and evaluation. CDC will continue to provide grantees with training necessary to implement PEMS and anticipates completion of training by August 2008. With this assistance CDC expects to gradually increase the percentage of grantees that use PEMS to monitor their programs. Data on PEMS usage in 2007 will be available in November 2008.

Long Term Objective 2.1, Performance Measure 7:

This measure addresses the number of evidence-based prevention interventions that are packaged and available for use in the field by prevention program grantees. CDC conducts systematic reviews to identify efficacious HIV prevention behavioral interventions based on rigorous efficacy criteria. After an intervention has been identified as effective, CDC "packages" the intervention through the Replicating Effective Programs (REP) Project. CDC then provides technical assistance and training to move effective HIV interventions into program practice. CDC plans to increase the number of interventions that are packaged and available for use in the field to 21 in FY 2009. Priority will be given to interventions that address the populations at highest risk for HIV transmission. Data for 2007 will be available in November 2008.

Long Term Objective 2.1, Performance Measure 8:

This measure addresses the number of agencies trained each year to implement evidence-based behavioral HIV prevention interventions. The Diffusion of Effective Behavioral Interventions (DEBI) project was designed to bring evidence-based, community-and group-level HIV prevention interventions to community-based service providers and state and local health departments. The goal is to enhance the capacity to implement effective interventions at the state and local levels, to reduce the spread of HIV and STDs, and to promote healthy behaviors. CDC supports training for community-based organization (CBO) staff nationwide to help CBOs implement effective prevention interventions for their local populations. By FY 2005, most CBOs funded by CDC had been trained on one or more DEBIs. Training is now focused on training replacement staff, newly funded CBOs, and on newly available DEBIs. Data for 2007 will be available in February 2008.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	FY 2015 Target
				Target	Actual	Target	Actual			
Long Term Objective 2.2: Decrease the rate of HIV transmission by HIV-infected persons.										
2.2.1	Decrease the rate of HIV transmission by HIV-infected persons. [O]	N/A	Baseline (8/2008)	N/A	3/2009	N/A	3/2010	TBD	TBD	TBD
2.2.2	Decrease risky sexual and drug using behaviors among persons at risk for transmitting HIV. [O]	N/A	N/A	N/A	N/A	Base-line	11/2008	11/2009	11/2010	N/A

Long Term Objective 2.2, Performance Measure 1:

This measure serves as both a long-term and annual measure. The target population for this measure is adults and adolescents (over 13 years of age). The ability to monitor the national HIV transmission rate is a fundamental indicator of the impact of HIV prevention activities in the U.S. Until recently, CDC was not able to monitor transmission rates because means were not

available to accurately monitor trends in new HIV infections. However, new laboratory methods now enable CDC to conduct HIV incidence surveillance. Today, CDC provides funding and technical assistance to selected state and local health departments to conduct HIV incidence surveillance. This surveillance system uses the STARHS methodology, a methodology developed by CDC staff to measure HIV incidence. Using residual serum specimens from standard HIV antibody testing, STARHS uses a less sensitive EIA to determine whether the person has been infected with HIV for less than six months (recent infection) or longer than six months (long-standing infection). Ongoing population-based data from funded areas are adjusted to impute annual national HIV incidence estimates. Residual serum specimens from diagnostic HIV antibody testing are tested with a second test, the BED-HIV-1 Capture Enzyme Immunoassay (BED Assay). The BED assay measures levels of a particular antibody (immunoglobulin G) in the blood. At the early stages of HIV infection this antibody exists at relatively low levels, and the BED assay results are used to classify specimens as recent (incident) or long-standing infections.

In the era of more effective therapies for HIV, Americans with HIV are living longer and the total number of Americans living with HIV is increasing. For example, from 2001-2005 the number of persons living with HIV/AIDS in the 33 areas with longstanding name-based HIV surveillance increased from an estimated 384,553 to 476,749. This measure takes into account the increasing number of persons who are living with HIV, and therefore at risk of transmitting the virus as a result of the new, life-prolonging treatments. CDC is working to decrease transmission rates by increasing the number of people who know they are infected and providing prevention services to those living with HIV. Baseline data are anticipated in mid-2008.

Long Term Objective 2.2, Performance Measure 2:

CDC will be able to monitor changes in risk behaviors among persons living with HIV through the Medical Monitoring Project (MPP), a second generation surveillance system which has been developed and piloted and will be implemented in the field in FY 2007. When fully implemented, MMP will be a nationally representative, population-based surveillance system assessing clinical outcomes, behaviors, and quality of care among HIV-infected persons who are in medical care. HIV-infected persons are interviewed about sexual and drug-using behaviors that may put them at risk for transmitting HIV. MMP replaces CDC's Supplemental HIV/AIDS Surveillance (SHAS), a convenience sample surveillance system which had provided data on HIV-infected persons in care in 16 areas. It is likely that baseline reporting using MMP may be delayed due to delayed implementation of MMP in the field.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	FY 2015 Target
				Target	Actual	Target	Actual			
Long Term Objective 2.3: Decrease risky sexual and drug using behaviors among persons at risk for acquiring HIV.										
2.3.1	Decrease risky sexual and drug-using behaviors among persons at risk for acquiring HIV. [O]	MSM - 47%	IDU – 11/2008	Base-line	HRH – 12/2008	MSM - 47%	12/2008	TBD	TBD	HRH - TBD
2.3.2	Increase the proportion of persons at risk for HIV who received HIV prevention interventions. [O]	MSM – 18.9%	IDU – 12/2008	Base-line	HRH – 12/2008	MSM – 20%	12/2009	IDU – TBD	HRH – TBD	N/A

Long Term Objective 2.3, Performance Measure 1:

This long term and annual measure addresses persons who are at increased risk of acquiring HIV due to risky sexual or drug-using behaviors. CDC supports prevention activities for persons who are uninfected and at behavioral risk of infection. National HIV Behavioral Surveillance (NHBS) is a nationally representative behavioral surveillance system that collects risk behavior data from three populations at risk for acquiring HIV: men who have sex with men (MSM), injection drug users (IDUs), and high risk heterosexuals in areas where HIV is prevalent (HRH). It utilizes survey sampling techniques developed in the past few years to reach representative samples of at-risk populations. NHBS was initiated in 2004, is conducted on an annual basis, and is limited during each cycle to one of these three study groups. Because of the survey cycle, different targets are set for the respective populations surveyed for the different years. MSM data and targets have been established.

New, effective treatments for HIV have resulted in increased risk taking behavior among MSM. This is reflected in increased self-reported risk behavior, STD infections, and increased HIV diagnoses. Other factors have also combined to increase risk among MSM, such as methamphetamine use, use of the Internet to meet new sexual partners, and beliefs regarding the severity of HIV disease. Because of the difficulties in changing behaviors on a population-wide basis, and in the face of countervailing trends, only modest decreases in this measure can be expected over the next several years without substantial infusion of new resources.

Long Term Objective 2.3, Performance Measure 2:

This measure addresses the extent to which at-risk individuals have received HIV prevention interventions (participation in an individual or small group prevention intervention). A number of interventions, conducted at both the individual and group levels, have been shown to be effective in reducing risk behaviors. CDC supports such interventions for persons who are at risk of infection. This measure addresses persons who had recently (within the past 12 months) received an intervention and does not measure the cumulative effect of evidence-based HIV prevention efforts. The NHRS system also serves as the data source for this measure.

Baseline data for MSMs were first reported at the time of the OMB PART Review. Baseline data for IDUs are now expected to be reported in December 2008. Although data collection and data entry of the IDU data is completed, reporting of the baseline IDU data will be delayed. The complex sampling methods used to recruit IDUs at the local level necessitates statistical weighting of the data to be representative of the entire population of IDUs. The weighting process of the baseline data is proceeding less quickly than anticipated, due to technical challenges, the need to rigorously review the baseline weights and recent staff turnover.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	FY 2015 Target
				Target	Actual	Target	Actual			
Long Term Objective 2.4: Increase the proportion of HIV-infected people in the United States who know they are infected.										
2.4.1	Increase the proportion of HIV-infected people in the United States who know they are infected. [O]	N/A	Baseline (8/2008)	N/A	N/A	N/A	N/A	N/A	N/A	80%
2.4.2	Increase the proportion of persons with HIV-positive test results from publicly funded counseling and testing sites who receive their test results. [O]	84%	83% (Un-met)	86%	10/2008	87%	10/2009	88%	90%	N/A
2.4.3	Increase the proportion of people with HIV diagnosed before progression to AIDS.[1] [O]	77.8%	76.5%	78%	3/2008	79%	3/2008	79%	80%	N/A

[1]As measured in the 33 states with mature, confidential, name-based HIV reporting in 2005. These are Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

Long Term Objective 2.4, Performance Measure 1:

Decreasing the prevalence of undiagnosed HIV infection has been a key prevention priority for CDC. CDC has facilitated HIV testing through publicly funded HIV counseling and testing, targeted distribution of rapid HIV tests, social marketing campaigns, and revised recommendations promoting routine HIV screening in health-care settings. CDC estimates that, in 2003, approximately 75 percent of the approximately one million persons living with HIV are aware that they are infected. However, increasing the proportion of people who know their HIV status is an ongoing prevention challenge.

Some persons with undiagnosed HIV infection (particularly those with recent infection) may not seek testing because they do not believe they are at risk for HIV infection. Others are aware they may be at risk but avoid testing (or being re-tested) because of fear of learning they are HIV-infected. In September 2006, CDC issued Revised Recommendations for HIV Screening of Adults, Adolescents, and Pregnant Women in Health-Care Settings. CDC is addressing challenges to implementation of HIV screening in health-care settings through a multidisciplinary approach that includes: policy diffusion strategies; partnerships with organizations of healthcare professionals; coordination with other federal agencies; implementation guidance; professional education materials; monitoring and evaluation strategies; social marketing; and strategies to ensure follow up care for HIV-infected persons. CDC will assess progress on this measure using special analyses of HIV case surveillance data. Baseline data are anticipated in mid-2008.

Long Term Objective 2.4, Performance Measure 2:

This measure addresses persons tested for HIV in publicly-funded HIV testing and counseling sites. Historically, a large proportion (up to 50 percent in some settings) of persons tested for HIV did not return to the clinic to receive their test results. This represented considerable lost opportunities for HIV prevention. Consequently, emphasis is placed on providing test results to those persons with HIV positive test results. These data were captured by Counseling, Testing, and Referral System (CTR), and are now being incorporated into PEMS. The proportions of

HIV-infected persons who received their HIV positive test results increased slightly from 81 percent in 2001 to 83 percent in FY 2005. CDC anticipates making continued progress in this area through efforts to increase utilization of rapid testing and continued emphasis on outreach to persons who test positive.

Long Term Objective 2.4, Performance Measure 3:

This measure addresses the proportion of HIV-infected individuals whose infection is diagnosed before progression to AIDS. Since the mid-1990s, effective medical therapies for HIV infection and associated opportunistic infections have dramatically reduced death rates associated with HIV infection. Age-adjusted mortality due to HIV disease declined from approximately 17 per 100,000 population in 1995 to less than six per 100,000 population in 2002. In order to take advantage of more effective therapies and prevent transmission to others, individuals should be aware of their infection early in the course of the disease, before progression to AIDS. The proportion of persons with HIV infection diagnosed before progression to AIDS declined slightly from 78.1 percent in 2002 to 76.5 percent in 2005.

CDC aims to increase early diagnosis by promoting HIV testing. To this end, the agency issued revised recommendations for HIV testing in medical care settings in 2006 and, in 2007, funded an initiative to promote increased testing in jurisdictions with the highest rates of disease among African Americans. 2008 and 2009, CDC will continue to support this initiative and will continue to work with insurers and medical care providers to increase the uptake of its HIV screening recommendations.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	FY 2015 Target
				Target	Actual	Target	Actual			
Long Term Objective 2.5: Increase the proportion of HIV-infected persons who are linked to prevention and care services.										
2.5.1	Increase the percentage of HIV-infected persons in publicly funded counseling and testing sites who were referred to Prevention Counseling and Referral Services (PCRS). [O]	N/A	N/A	N/A	N/A	N/A	N/A	Baseline (11/2009)	N/A	TBD
2.5.2	Increase the percentage of HIV-infected persons in publicly funded counseling and testing sites who were referred to medical care and attended their first appointment. [O]	N/A	N/A	N/A	N/A	N/A	N/A	Baseline (11/2009)	TBD	N/A
2.5.3	Increase the percentage of HIV-infected persons in publicly funded counseling and testing sites who were referred to HIV prevention services. [O]	N/A	N/A	N/A	N/A	N/A	N/A	Baseline (11/2009)	TBD	N/A
2.5.4	Increase the percentage of HIV-infected persons in medical care who initiated medical care within three months of diagnosis. [O]	N/A	N/A	N/A	N/A	Establish baseline	(11/2009)	N/A	TBD	N/A

Long Term Objective 2.5, Performance Measure 1:

This long term measure addresses persons tested for HIV in publicly-funded HIV testing and counseling sites. Prevention Counseling and Referral Services (PCRS) is a key component of CDC's HIV prevention activities. Through PCRS, infected persons are counseled about the importance of notifying their partners and provided skills for this notification. Notified partners can choose whether to be tested, and receive relevant counseling and prevention services.

Data for this measure will come from PEMS, with baseline data for FY 2008 available in November 2009. Currently, more than 1,250 agencies, including health departments and CBOs across the country, have access to PEMS. CDC has considered the needs and capacities of these widely differing organizations in developing and refining PEMS. To this end, CDC has held several stakeholder meetings and is currently piloting PEMS in both state and local health departments and among CBOs.

Long Term Objective 2.5, Performance Measure 2:

This measure addresses referral to medical care for persons tested for HIV in publicly-funded HIV testing and counseling sites and found to be HIV-infected. In order to best protect their health, individuals should receive care for their infection as soon as possible after being diagnosed with HIV. Such care can help ensure that related risk factors and comorbidities are addressed, and that appropriate therapies are begun in a timely manner. CDC works with prevention providers and with care and treatment providers to help ensure that individuals who are found to be infected are link to appropriate medical care. Early medical intervention can reduce the likelihood of developing AIDS and offers an important opportunity for HIV prevention. Data for this measure will come from PEMS, with baseline data for FY 2008 available in November 2009.

Long Term Objective 2.5, Performance Measure 3:

This measure addresses referral to prevention services for persons tested for HIV in publicly-funded HIV testing and counseling sites and who were found to be HIV-infected. CDC supports prevention services among HIV-infected individuals to reduce risk of transmission. These services are not necessarily offered at the testing and counseling facility. Therefore, HIV-infected individuals may need referral to another organization or facility. CDC has placed a priority on providing services to HIV-infected individuals and has recently issued guidance to program areas to provide comprehensive risk counseling and services for HIV-infected individuals. CDC has co-authored recommendations for prevention of HIV prevention services in medical care settings and has worked with the Health Resources and Services Administration (HRSA), the National Association of Community Health Centers, the American Hospital Association, and a wide range of professional medical associations to increase the number of clinical sites that offer HIV testing as part of routine medical care and to develop referral and linkage procedures for HIV-infected and high-risk. Data for this measure will come from PEMS, with baseline data for FY 2008 available in November 2009.

Long Term Objective 2.5, Performance Measure 4:

This measure addresses initiation of medical care for those recently diagnosed with HIV. CDC will be able to monitor changes in risk behaviors and provision of care among persons living with HIV through the Medical Monitoring Project (MMP), a second generation surveillance system which has been developed and piloted and will be implemented in the field in 2007. When fully implemented, MMP will be a nationally representative, population-based surveillance system assessing clinical outcomes, behaviors, and quality of care among HIV infected persons who are in medical care. HIV-infected persons are interviewed about sexual and drug-using behaviors that may put them at risk for transmitting HIV. Baseline data for FY 2007 will be available in November 2008.

VIRAL HEPATITIS

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	FY 2015 Target
				Target	Actual	Target	Actual			
Long Term Objective 2.6: Reduce the rates of viral hepatitis in the United States.										
2.6.1	Reduce the rate of new cases of hepatitis A (per 100,000 population). [O]	N/A	1.9/ 100,000	2.6/ 100,000	1.2/ 100,000 (Met)	2.5/ 100,000	7/2008	2.4/ 100,000	2.4/ 100,000	2.0/ 100,000
2.6.2	Reduce the rate of new cases of hepatitis B (per 100,000 population). [O]	2.1/ 100,000	1.9/ 100,000	N/A	1.6/ 100,000	1.9/ 100,000	7/2008	1.8/ 100,000	1.8/ 100,000	1.5/ 100,000
2.6.3	Increase the proportion of individuals knowing their hepatitis C virus infection status. [O]	<50%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	65%
2.6.4	Increase the number of areas reporting chronic hepatitis C virus infections to CDC to 50 states and New York City and District of Columbia.	24	29	N/A	N/A	N/A	36	33	35	37

Long Term Objective 2.6, Performance Measure 1:

This measure addresses hepatitis A virus (HAV) incidence. HAV is spread by close contact with infected persons or ingestion of contaminated food. Vaccination, outbreak response, and food safety programs are the primary interventions used to prevent HAV. HAV incidence has decreased by approximately 88 percent nationwide since the mid-1990s, when HAV vaccine became available and the first vaccination recommendations were released. HAV incidence in FY 2006 was 1.2 cases per 100,000 population. HAV incidence has declined by 99 percent among Alaska Natives and American Indians, populations with the highest disease rates in the pre-vaccine era. This reduction has effectively eliminated a racial disparity in health.

Declines in the overall incidence of HAV infection have been accompanied by shifts in the epidemiologic profile of the disease. Large communitywide outbreaks that occurred as a result of person-to-person contact in households and extended family settings have become increasingly rare. As this type of transmission has decreased, the proportion of cases among persons in high-risk populations, specifically international travelers, illicit-drug users, and men who have sex with men (MSM) has increased.

As one of the nationally notifiable diseases, it is mandated that any case of diagnosed HAV should be reported to local health authorities. FY 2007 data are due to be reported in July 2008.

Long Term Objective 2.6, Performance Measure 2:

This measure addresses hepatitis B virus (HBV) incidence. HBV is spread by exposure to infectious blood or body fluids or through sexual contact. HBV infection can become chronic in some persons and lead to death from cirrhosis or liver cancer. Approximately one to 1.25 million persons has chronic HBV, and 3,000–5,000 die each year.

Rates of new HBV infection in the U.S. have declined over the past decade and are linked to the successful implementation of vaccination strategies as well as progress in screening and awareness. HBV incidence in FY 2006 was 1.6 cases per 100,000 population. FY 2007 data are due to be reported in July 2008.

As a result of the national HBV elimination strategy, the 2006 incidence rate surpasses the Healthy People 2010 goal of 4.5 cases per 100,000 population. However, rates among persons aged 25-44, particularly among males, remain substantially higher than any other age group. CDC aims to continue to reduce the rate of HBV cases in the U.S.

More than 95 percent of pregnant U.S. women are now screened for HBV infection during pregnancy, reducing the risk for perinatal transmission. Implementation of recommendations for routine infant and adolescent vaccination has been accompanied by a 98 percent decline since 1990 in incidence among children aged <15 years.

Key components of CDC efforts to prevent HBV-related morbidity and mortality are 1) vaccination of newborns, infants, and children and of adults at increased risk of infection; and 2) identification and referral of HBV-infected persons for public health management and treatment, with a focus on persons from HBV-endemic countries and others with high prevalence of chronic HBV infection.

In 2003, chronic HBV infection was added to the list of notifiable diseases, so any case of diagnosed HBV should be reported to local health authorities.

Long Term Objective 2.6, Performance Measure 3:

This long term measure addresses knowledge of hepatitis C virus (HCV) status. HCV is the most common bloodborne viral infection and a leading cause of death from liver cancer. Approximately three million persons in the U.S. have chronic HCV. Most HCV-infected persons are unaware of their infection, increasing the risk that they will transmit the virus to others and suffer poor health outcomes themselves. In FY 2004, the baseline year, less than 50 percent of this population was aware of their HCA status.

In the absence of an HCV vaccine, the goals of HCV prevention are early identification of infection, behavior modification to avoid HCV exposure, and referral for treatment. Knowledge of chronic HCV infection status is a critical determinant of whether patients receive treatment and adopt preventative health behaviors. In 2003, chronic HCV infection was added to the list of notifiable diseases, so any case of diagnosed HCV should be reported to local health authorities.

Data collected from The National Health and Nutrition Examination Survey (NHANES) can be used to estimate the proportion of HCV-infected persons in the U.S. who know their HCV status. Due to the ongoing nature of NHANES, CDC can assess trends in this knowledge over time. CDC is working to achieve the FY 2015 target of 65 percent.

Long Term Objective 2.6, Performance Measure 4:

Surveillance for chronic HCV infection is critical for planning public health prevention activities, determining unmet healthcare needs, and evaluating ongoing prevention programs. As noted, chronic HCV infection was added to the list of notifiable diseases in 2003, so any case of diagnosed HCV should be reported to local health authorities. However, national surveillance for chronic HCV infection remains incomplete in large part due to a high volume of reports and inadequate staff resources at the state and local levels. Efforts to increase jurisdictions that report cases of chronic HCV infection to CDC will substantially improve our ability accurately to describe the epidemiologic characteristics of these cases nationally.

SEXUALLY TRANSMITTED DISEASES

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2015 Target
Long Term Objective 2.7: Reduce the rates of non-HIV sexually transmitted diseases (STDs) in the United States.										
2.7.1	Reduce pelvic inflammatory disease in the U.S. [O]	132,000	176,000	N/A	106,000	N/A	N/A	N/A	N/A	<150,000
2.7.2	Reduce the prevalence of chlamydia among high-risk women under age 25. [O]	9.7%	9.2%	9.3%	13.1% (Unmet)	9.3%	10/2008	9.0%	8.7%	8.5%
2.7.3	Reduce the prevalence of chlamydia among women under age 25, in publicly funded family planning clinics. [O]	6.3%	6.3%	6.3%	6.7% (Unmet)	6.3%	10/2008	6.3%	6.3%	6.3%
2.7.4	Reduce the incidence of gonorrhea in women aged 15 to 44 (per 100,000 population). [O]	267/ 100,000	276/ 100,000	278/ 100,000	290/ 100,000 (Unmet)	278/ 100,000	10/2008	276/ 100,000	276/ 100,000	<276/ 100,000
2.7.5	Eliminate syphilis in the U.S.[1] [O]	2.7/ 100,000	3.0/ 100,000	N/A	3.3/ 100,000	N/A	N/A	N/A	N/A	<3.2/ 100,000
2.7.6	a) Reduce the incidence of P&S syphilis in men (per 100,000 population).[1] [O]	4.7/ 100,000	5.1/ 100,000	New Baseline[1]	5.7/ 100,000	4.5/ 100,000	10/2008	5.5/ 100,000	5.4/ 100,000	<5.4/ 100,000
	b) Reduce the incidence of P&S syphilis in women (per 100,000 population). [O]	0.8/ 100,000	0.9/ 100,000	0.58/ 100,000	1.0/ 100,000 (Unmet)	0.8/ 100,000	10/2008	0.9/ 100,000	0.9/ 100,000	<0.9/ 100,000
2.7.7	Reduce the incidence of congenital syphilis per 100,000 live births. [O]	9.1/ 100,000	8.2/ 100,000	8.8/ 100,000	8.5/ 100,000 (Met)	8.8/ 100,000	10/2008	8.5/ 100,000	8.5/ 100,000	<8.5/ 100,000
2.7.8	Reduce the racial disparity of P&S syphilis (reported ratio is black:white). [O]	5.5:1	5.4:1	5.6 to 1	5.9:1 (Unmet)	5.6 to 1	10/2008	5.5 to 1	5.4 to 1	<5.4 to 1

[1]In FY 2002, the incidence of P&S syphilis in men was 3.8 per 100,000 (initial 2002 baseline). However, because an outbreak of syphilis among men who have sex with men that occurred after 2002 has driven up the male syphilis rates, CDC is reporting a new baseline for 2006. The goal for 2015 for P&S syphilis takes into account the outbreak, expectations for control and reversing the trend. The annual targets for 2008 – 2010 also take this outbreak into account.

Long Term Objective 2.7, Performance Measure 1:

More than 50 percent of all preventable infertility among women is a result of STDs, primarily chlamydia and gonorrhea. Because most infected women and at least one half of infected men have no symptoms or have such mild symptoms that they do not seek medical care, many infections go undetected and are not reported or counted. Untreated chlamydia and gonorrhea infections can cause severe and costly reproductive and other adverse health consequences, including pelvic inflammatory disease (PID), which can lead to infertility. An estimated 10 to 40 percent of women with untreated chlamydia or gonorrhea will develop PID which can result in ectopic pregnancy, chronic pelvic pain, and infertility.

This is a long term measure with no annual targets. The actual performance for this measure was 106,000 visits to the physician for PID by women 15 to 44 years of age compared to the

2015 target of <150,000 visits. Visits to the physician for PID by women 15 to 44 years of age have decreased from 123,000 in 2003 to 106,000 in 2006.

It may appear that the 2015 target for this measure was not set at an appropriate level because the 2006 data exceeds this target; however, it is challenging to monitor trends in the incidence of PID for several reasons. First, diagnosis is based on clinical criteria that are often vague (symptoms of lower abdominal pain and pelvic tenderness), so making a diagnosis is imprecise, with both under- and over-diagnosis possible. Second, given this imprecision, it is not a nationally notifiable condition. Thus, measuring national PID trends has been based on the use of National Disease and Therapeutic Index (NDTI), an administrative dataset that contains information on the number of initial visits to physicians for PID by women 15 to 44 years of age. These data have limitations, including small sample sizes and limited representation; clinical facilities included only serve part of the U.S. population. From a 2002 baseline of 197,000 visits, the number dropped significantly in 2003 to 123,000, then rose gradually in 2004 to 132,000; rose sharply in 2005 to 176,000; then dropped significantly in 2006 to 106,000. Because national estimates of the prevalence and incidence of gonorrhea and chlamydia have been stable, these significant fluctuations in PID seem unlikely. CDC researchers are investigating potential use of additional national medical care survey data for PID trends to develop more robust and stable measures. And, while the large fluctuations are problematic, the general trend downward from the baseline will be evaluated by CDC with an eye toward re-setting the 2015 target.

Long Term Objective 2.7, Performance Measures 2 and 3:

For Performance Measure 2, CDC monitors trends in prevalence among women enrolled in the U.S. Department of Labor National Job Training Program (NJTP) for economically disadvantaged women aged 16 to 24. This measure reflects the prevalence of chlamydia infection in a population of high-risk young women who are not seeking health care. They are routinely screened as part of their enrollment in the program.

The actual performance for FY 2006 for Measure 2 was 13.1 percent of women entering the National Job Training Program who tested positive for Chlamydia compared to the target of 9.3 percent. The performance target for this measure was set at an approximate target level; however the deviation from that level is significant and material. Chlamydia prevalence in women entering the NJTP has substantially increased from 9.9 percent in 2003 to 13.1 percent in 2006. In 2005, among women entering the program, chlamydia prevalence was 9.2 percent. Chlamydia prevalence among women entering the program decreased steadily from 2003 (9.9 percent) to 2005 (9.2 percent) until the introduction of a more sensitive test in 2006, at which point Chlamydia prevalence significantly increased to 13.1 percent. Among men entering the program in 2006, chlamydia prevalence was 7.9 percent, which is little change from the chlamydia prevalence of 8.1 percent in 2005. There was no change in the test types used among men. In 2009, CDC will analyze prevalence data from 2007 and preliminary data to 2008 to determine if the long term target should be adjusted to reflect the more widespread use of the more sensitive tests within the NJTP.

Performance Measure 3 reflects prevalence of Chlamydia in a population of young sexually active women seeking reproductive health care. CDC's Infertility Prevention Program (IPP) provides funding to Title X Family Planning Clinics to screen women for chlamydia in accordance with CDC's recommendation that all sexually-active women under age 26 be screened annually for chlamydia.

The actual performance for FY 2006 for Measure 3 was 6.7 percent of women under age 25 who tested positive for Chlamydia in funded family planning clinics compared to the target of 6.3 percent. The performance target for this measure was set at an approximate target level, and

the deviation from that level is slight. There was no effect on overall programs or activity performance. Chlamydia prevalence in women under age 25 in publicly-funded family planning clinics has increased from 5.9 percent in 2003 to 6.7 percent in 2006.

Reported chlamydial infections have increased, reflecting the expansion of screening activities, increased use of the most sensitive diagnostic tests, an emphasis on case reporting from providers and laboratories, and improvements in reporting systems. Increases in reported chlamydial infections are likely to continue as screening expands to more public and private medical settings. In 2000, the Health Plan Employer Data and Information Set (HEDIS) introduced a measure for chlamydia screening of sexually active women, 16 through 25 years of age, who receive their medical care through managed care organizations. The promulgation of and adherence to this measure are also likely to increase screening and reporting practices in the private sector. Because of these expected increases, the target for flat prevalence rates is ambitious, though realistic within the current resource context. In 2009, CDC aims to reduce increases in infection and has set targets for no increase in reported cases in family planning clinics. In 2006, 76 percent of Chlamydia cases, 65 percent of gonorrhea cases, and 65 percent of primary and secondary syphilis cases were reported from non-STD clinic settings. Because STDs are increasingly diagnosed outside of STD clinics, in 2009, CDC will broaden its efforts to include new partnerships with professional organizations, private health care providers, other public health care settings and outreach to the public, while maintaining its support and work within the public STD and family planning clinics. Chlamydia screening is ranked as highly-cost effective clinical preventive service with low delivery rate (<50 percent adherence to guidance in the private sector). CDC has set a priority to increase chlamydia screening rates nationally and has developed an initiative to engage partners in the private sector on this important reproductive health issue.

Long Term Objective 2.7, Performance Measure 4:

It is estimated that more than 50 percent of all preventable infertility among women is a result of STDs, primarily chlamydial infection and gonorrhea. Because most infected women, and at least one half of infected men, have no symptoms or have such mild symptoms that they do not seek medical care, many infections go undetected and are not reported or counted. In fact, it is estimated that 2.8 million new chlamydial infections and 700,000 gonorrheal infections occur each year in the U.S. In women, untreated gonorrhea can cause severe and costly reproductive and other adverse health consequences, including PID, which can lead to infertility, ectopic pregnancy, and chronic pelvic pain.

The actual performance for this measure was 290 cases of gonorrhea per 100,000 women aged 15 to 44 compared to the target of 278 per 100,000 women aged 15 to 44. The performance target for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall programs or activity performance. This measure provides our best national data on gonorrhea incidence among women of reproductive age. Gonorrhea prevalence in women aged 15 to 44 has increased from 268 per 100,000 in 2003 to 290 per 100,000 in 2006. In 2009, CDC aims to halt these increases and bring rates in women down to 2005 levels.

Long Term Objective 2.7, Performance Measure 5:

Persistence of syphilis is a sentinel public health event with important social and historical significance. Syphilis is preventable and curable. Syphilis increases efficiency of HIV transmission two to five-fold and is associated with serious morbidity on its own (e.g., serious illness in babies, strokes and other neurologic disease). This data provides the best national data on the incidence of the early, symptomatic stages of syphilis (i.e., primary and secondary

[P&S syphilis]). CDC will work to achieve interim indicators progressing toward the long term goal of elimination.

This is a long term measure with no annual target. In FY 2006, STD surveillance shows 3.3 cases of P&S syphilis per 100,000. P&S syphilis cases increased from 2.5 cases per 100,000 in 2003 to 3.3 cases per 100,000 in 2006. In 2009, CDC aims to reverse these increases by redoubling prevention for MSM while supporting effective interventions to sustain prevention and control among heterosexual men and women. To better ensure that syphilis prevention and control interventions are evidence-based and targeted to populations with greatest needs, CDC, in October 2007, instituted the Syphilis Elimination Evidence-based Action Planning process for all project areas receiving SE funds. This monitoring process is designed to improve program monitoring by promoting better analysis of local surveillance data and program performance indicators. CDC carefully reviews each of the submitted action plans and provides guidance and technical assistance as warranted to ensure the appropriateness and effectiveness of intervention activities. These program strategies are applicable for all of the supporting annual measures which are subsequently discussed.

Long Term Objective 2.7, Performance Measure 6a:

Beginning in 2001, syphilis rates among men began to rise, after declining since 1991. Between 2005 and 2006, the national P&S syphilis rate increased 13.8 percent, from 2.9 to 3.3 cases per 100,000 population, and the number of cases increased from 8,724 to 9,756. The overall increase in syphilis rates from 2005 to 2006 was driven primarily by increases among males in addition to an increased the rate among females for the second year in a row, following a decade of declines.

The actual performance for FY 2006 for this measure was 5.7 cases of P&S syphilis per 100,000 population in males. In FY 2002, the incidence of P&S syphilis in men was 3.8 per 100,000 (initial 2002 baseline). However, because an outbreak of syphilis among men who have sex with men that occurred after 2002 has driven up the male syphilis rates, CDC is reporting a new baseline for 2006. The goal for FY 2015 for P&S syphilis takes into account the outbreak, expectations for control and reversing the trend. The annual targets for P&S syphilis in men for 2008 – 2010 also take this outbreak into account. P&S syphilis cases in men increased from 4.2 cases per 100,000 in 2003 to 5.7 cases per 100,000 in 2006.

Data suggested and additional studies confirmed that the great majority of cases in men were attributable to transmission among men who have sex with men (MSM), many of whom are at high-risk for transmitting or acquiring HIV infection. Traditional approaches to syphilis prevention are less-effective in this population, and reducing syphilis among MSM requires different approaches from those used with women. CDC is also ensuring the increased application of evidence-based approaches to this target group through the use of the SE Evidence-based Action Planning process and by facilitating peer-to-peer technology transfer through organized monthly web-based seminars during which lessons learned and emerging best practices are shared and discussed.

Long Term Objective 2.7, Performance Measure 6b:

Between 2005 and 2006, the national P&S syphilis rate increased 13.8 percent, from 2.9 to 3.3 cases per 100,000 population, and the number of cases increased from 8,724 to 9,756. The overall increase in syphilis rates from 2005 to 2006 was driven primarily by increases among males in addition to an increased rate among females for the second year in a row, following a decade of declines (from 0.9 per 100,000 in 2005 to 1.0 in 2006).

The actual performance for FY 2006 for this measure was 1.0 case of P&S syphilis per 100,000 population of females compared to the target of 0.58 cases per 100,000 population. The

performance target for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall programs or activity performance. Primary and secondary syphilis cases in women increased from 0.8 cases per 100,000 in 2003 to 1.0 case per 100,000 in 2006.

As mentioned above, the prevention approaches used with women are different from those used with MSM and the complications of infection are also different (risk of transmission to babies). Through this measure CDC monitors its progress in addressing syphilis among women and continues to substantively support syphilis and STD prevention services to women aimed at reducing adverse outcomes of pregnancy.

Long Term Objective 2.7, Performance Measure 7:

When a woman has a syphilis infection during pregnancy, she may transmit the infection to the fetus in utero. This often results in fetal death or an infant born with physical and mental developmental disabilities. Most cases of congenital syphilis are easily preventable if women are screened for syphilis and treated early during prenatal care, as recommended by CDC and other professional health organizations and required in all 50 states. CDC is an actively engaged partner in the WHO initiative to eliminate congenital syphilis.

The actual performance for FY 2006 for this measure was 8.5 cases of congenital syphilis per 100,000 live births compared to the target of 8.8 cases per 100,000 live births. The performance target for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall programs or activity performance. Congenital syphilis cases decreased from 10.6 cases per 100,000 in 2003 to 8.5 cases per 100,000 in 2006.

Long Term Objective 2.7, Performance Measure 8:

Syphilis remains an example of racial disparity in health, with historical and sociological significance that is important to be addressed. In 1997, prior to initiation of the National Plan to Eliminate Syphilis from the United States, the Black:White rate ratio was 43:1 and by 2006 has dropped to 5.9:1. Through this measure CDC monitors its progress in reducing this important historic disparity while addressing the new epidemic in syphilis among MSM.

The actual performance for FY 2006 for this measure was the Black:White ratio of P&S syphilis of 5.9:1 compared to the target of 5.6 to 1. The performance target for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall programs or activity performance. The racial disparity of primary and secondary syphilis has increased from 5 to 1 in 2003 to 5.9 to 1 in 2006.

TUBERCULOSIS

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	FY 2015 Target
				Target	Actual	Target	Actual			
Long Term Objective 2.8: Decrease the rate of cases of TB among U.S.-born persons in the United States.										
2.8.1	Decrease the rate of cases of TB among U.S.-born persons (per 100,000 population). [O]	2.6	2.5	2.2	2.3 (Unmet)	2.1	9/2008	1.9	1.8	1.7
2.8.2	Increase the percentage of TB patients who complete a course of curative TB treatment within 12 months of initiation of treatment (some patients require more than 12 months). [O]	82.3% (Unmet)	9/2008	86.2%	9/2009	87.3%	9/2010	>87.5%	>88.0%	>88.5%
2.8.3	Increase the percentage of TB patients with initial positive cultures who also have drug susceptibility results. [O]	92.9%	92.4%	95.1%	92.2% (Unmet)	95%	9/2008	95%	>95%	>95%
2.8.4	Increase the percentage of contacts of infectious (Acid-Fast Bacillus (AFB) smear-positive) cases that are placed on treatment for latent TB infection and complete a treatment regimen. [O]	43.3% (Un-met)	12/2008	59%	12/2009	43%	12/2010	> or = 43%	> or = 43%	> or = 43%

Long Term Objective 2.8, Performance Measure 1:

In the U.S., rates of TB have been declining for the past 14 years due to successful control measures begun in the early 1990s. Most of this decline is attributable to declines among U.S.-born persons. An estimated 9 to 14 million U.S. citizens have latent TB infection, and about 10 percent of these individuals will develop TB at some point in their lives. Those who are infected with HIV have a greater chance of developing TB. CDC works with state and local partners to identify and control TB in the U.S. Persons born outside the U.S. account for 57 percent of all U.S. TB cases, constituting a majority of cases for the fourth year in a row. Ensuring future declines in TB in the U.S. is dependent upon reducing TB among foreign-born persons and other high risk groups such as African Americans. This measure serves as both a long term and annual measure.

Long Term Objective 2.8, Performance Measure 2:

Because identification of TB cases and ensuring completion of TB treatment is the most effective way to reduce the spread of TB and prevent its complications, this objective is the highest priority for CDC's TB program. Its achievement is vital to reduce TB cases and eventually to eliminate TB. Importantly, completion of therapy is also critical to preventing the development of drug-resistant TB. Patients who do not complete therapy within 12 months are often difficult to treat, requiring therapies that are more expensive and difficult to tolerate. CDC supports outreach workers, generally hired from language, cultural, and ethnic groups with high TB incidence to help meet this objective. Outreach workers help patients complete treatment through directly observed therapy, provision of incentives and enablers to the patients and other adherence strategies. CDC also funds Regional Training and Medical Consultation Centers which provide training, medical consultation for treating patients, and educational materials for

health departments and healthcare providers. Progress has been made in achieving this measure and in 2004 over 80 percent of patients received a curative course of treatment during the 12 month period.

Long Term Objective 2.8, Performance Measure 3:

Healthcare providers must know if a newly diagnosed infectious patient is infected with drug-sensitive or drug-resistant organisms so that appropriate drug therapy can be initiated. If this information is unknown, patients may receive inadequate treatment leading to the spread of drug-resistant organisms, additional morbidity, and mortality. In 2006, drug susceptibility results were documented for over 92 percent of TB patients with initial positive cultures. Progress toward this measure is attributable to increased efforts of state and local health departments and hospital infection-control practitioners to address the resurgence of TB, as well as increased funding for health department laboratories to purchase state-of-the-art equipment needed to perform more accurate and rapid laboratory testing and confirmation for TB and multi-drug resistant TB.

Long Term Objective 2.8, Performance Measure 4:

Completion of treatment for latent TB infection among contacts of infectious TB cases is important in U.S. efforts to reduce TB and eliminate the disease, second only to ensuring identification and completion of treatment of persons with active TB using appropriate drugs. Contacts of smear-positive TB patients are at high risk of developing TB and therefore must be screened for infection. If infected, these contacts should be offered treatment for latent TB infection. CDC supports identifying and examining contacts of persons with active TB, as well as completion of treatment for contacts who have latent TB infection, through cooperative agreements with state and local health departments.

ZOONOTIC, VECTOR-BORNE, AND ENTERIC DISEASES

#	Efficiency Measure	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
3.E.1	Enhance detection and control of foodborne outbreaks by increasing the number of foodborne isolates identified, fingerprinted, and electronically submitted to CDC's computerized national database networks with annual level funding. [E]	18,729 (Exceed-ed)	22,684 (Exceed-ed)	24,866 isolates	27,618 (Exceed-ed)	28,633 isolates	32,665 (Exceed-ed)	32,069 isolates	35,276 isolates	N/A

Efficiency Measure 3.E.1:

PulseNet, an early warning system for outbreaks of foodborne disease, is a national network of public health laboratories that performs DNA fingerprinting on bacteria that may be foodborne. In FY 2007, PulseNet exceeded its target of 28,633 isolates identified, fingerprinted and electronically submitted to CDC's computerized national databases with annual level funding, by submitting 32,665 isolates total. The increase in submission enables PulseNet to detect more and smaller clusters of foodborne infections than ever before. Exceeding this target is related to ongoing CDC support for capacity building activities in state and local public health laboratories and increased coordination, education, and submissions from state and local partner laboratories as well as a very busy year with increased submissions from large multi-state outbreaks of E. coli O157 from ground beef and pepperoni pizza; salmonella infections from fresh tomatoes, peanut butter, vegan snacks, dried dog food, and chicken pot pies; and botulism from canned chili sauce. In FY 2004 to FY 2006, CDC exceeded its target for this measure by five to eleven percent, indicating the enthusiasm and commitment of the participants in the network. The target was exceeded in FY 2007 by more than 15 percent due to increased participation as well as an increased general volume of submissions. CDC will continue to increase the number of online submissions in FY 2008 and FY 2009 by increasing the number of individuals at the participating laboratories who are certified to electronically submit pulsed-field gel electrophoresis (PFGE) patterns directly to the database, in order to reach its overall target of 35,276 isolates annually submitted. CDC also provides funds to state and local laboratories to upgrade the instruments and equipment needed to conduct PFGE.

The targets for this measure were initially developed during the PART review of the former Infectious Disease program in 2004. Ambitious targets were set to more than double the number of annual isolates identified, fingerprinted, and electronically submitted from the baseline of 14,864 to 35,726. Although great progress has been made in meeting the annual targets, the overall target has not yet been exceeded and therefore has not raised its annual targets. This year's substantial submission above the target is related to ongoing capacity building efforts, increased collaboration and a general increase in the volume of foodborne isolates due to several multi-state, high profile outbreaks. Once the FY 2009 target of isolates is met, CDC is planning on retiring this measure, as it may no longer be the most appropriate measure for improving the food safety system. The PulseNet system may have reached a maximum annual capacity of isolates submitted and attention will be focused on gaining efficiencies and improving other aspects of the food safety program. The increased number of isolates annually submitted enables PulseNet to detect more and smaller outbreaks of foodborne infections, and once identified, concerted state and local control measures in concert

with the Food and Drug Administration (FDA) and the US Department of Agriculture's Food Safety Inspection Service (USDA/FSIS) have avoided potential illness.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	FY 2010 Target
				Target	Actual	Target	Actual			
Long Term Objective 3.1: Protect Americans from infectious diseases – foodborne illnesses.										
3.1. 1	By 2010, reduce the incidence of infection with four key foodborne pathogens by 50%. [O]									
	- *Campylobacter*	N/A	12.72 (Exceeded)	16.10	12.71 (Exceeded)	15.14	5/2008	14.20	13.25	12.30
	- *Escherichia coli* O157:H7	N/A	1.06 (Exceeded)	1.30	1.31 (Unmet)	1.22	5/2008	1.15	1.08	1.00
	- *Listeria monocytogenes*	N/A	0.30 (Exceeded)	0.33	0.31 (Exceeded)	0.31	5/2008	0.29	0.27	0.25
	- *Salmonella* species	N/A	14.55 (Unmet)	8.90	14.81 (Unmet)	8.39	5/2008	7.84	7.31	6.80

Long Term Objective 3.1, Performance Measure 1:

Foodborne illness is recognized as a significant public health problem in the U.S. A 1999 estimate from CDC attributes 76 million illnesses, 325,000 hospitalizations, and 5,000 deaths annually to foodborne pathogens. This measure supports tracking new and total cases of the most common foodborne diseases in order to focus activities of relevant food safety regulatory agencies on the most common, or most difficult pathogens and to reduce the overall burden of foodborne diseases. This goal was established as part of the Healthy People 2010 (HP2010) process. Although CDC tracks progress towards these goals, this measure is assigned to the Food and Drug Administration (FDA) as part of the HP 2010 process. Regulation of the food supply is the responsibility of the FDA and the US Department of Agriculture (USDA). CDC monitors and investigates human illness resulting from contaminated food and provides information on these illnesses and outbreaks to the regulatory agencies so they can develop and implement effective control measures.

Campylobacter

The FY 2006 target for Campylobacter has been exceeded, although it has not yet reached the FY 2010 target. Targets were set based upon historical baselines as part of the HP 2010 process. Preventive measures implemented by the FDA, and the USDA's Food Safety and Inspection Service (USDA/FSIS), and others are achieving significant public health outcomes in the effort to reduce the incidence of foodborne illness. CDC, FDA, USDA/FSIS and other partners are still working on reaching the HP 2010 goal, and have begun discussions about setting ambitious goals as part of the Healthy People 2020 (HP 2020) Process.

E. coli

The measure for E.coli was not met for FY 2006. The performance target was set at an approximate target level, and the deviation from that level is slight. After the incidence of E.coli O157 infections declined to a low in 2004, it increased again in the last two years, returning to previous levels. This recent increase is unlikely to be related to contamination of ground beef, which remains at low levels, and may be related to contamination of fresh produce and other foods. Following several large multi-state outbreaks of E.coli O157 in FY 2007, rates may increase, and targets may need to be adjusted. Interagency dialogue is underway with our regulatory partners and with industry to increase the development and application of effective prevention strategies for E. coli O157 in produce and other foods to decrease these rates in the future.

Listeria

The targets for Listeria were met in FY 2005 and FY 2006. The performance targets have been set at an approximate target level and it has only been slightly exceeded. The overall 2010 goal has not been met. In collaboration with FDA and USDA/FSIS, CDC continues broad implementation of a national Listeria Action Plan to further reduce Listeria cases through efficient risk management, empowering consumers, and improving consumer safety.

Salmonella

The targets for Salmonella were not met in FY 2005 and FY 2006. Rates of infection with Salmonella have not changed significantly since 1996. This may reflect continuing salmonella contamination of poultry, meat, and the environment in which produce is grown and processed. New interagency efforts in research and interventions to improve the effectiveness of food safety measures for Salmonella are now underway. Additionally USDA/FSIS has announced a major salmonella initiative in February 2006 that included several components including focusing testing on the establishments having the most difficulty in controlling salmonella. FDA, USDA/FSIS, and CDC will be looking at revising these targets as plans are initiated for Healthy People 2020.

PREPAREDNESS, DETECTION, AND CONTROL OF INFECTIOUS DISEASES

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	FY 2010 Target
				Target	Actual	Target	Actual			
Long Term Objective 4.1: Reduce the spread of antimicrobial resistance.										
4.1.1	Decrease the number of antibiotics prescribed for ear infections in children under 5 years of age per 100 children. [O]	N/A	50 (Exceeded)	60 courses	2/2008	60 courses	2/2009	57 courses	55 courses	50 courses

Long Term Objective 4.1, Performance Measure 1:

CDC's public health campaign *Get Smart: Know When Antibiotics Work* involves an alliance of partners working to reduce inappropriate antibiotic use and reduce the spread of resistance to antibiotics. By reducing the number of courses of antibiotics for ear infections for children less than five years there will be a reduction in unnecessary antibiotic use leading to improved healthcare quality, cost savings and reduction in the development of antibiotic resistance.

This measure is based on a Healthy People (HP 2010) goal for which targets were established in 2000. When the goal was set in 2000 the practice of prescribing antibiotics for ear infections was much more common and the average rate for the baseline was 69 antibiotic courses. The measure was recently revised because performance in reducing antibiotic prescriptions for ear infections had already exceeded the 2010 target of 57 courses. As the program establishes goals through the HP 2020 process, this performance measure will be revisited to ensure that it is appropriately representative of efforts to reduce antimicrobial resistance and that targets are appropriately ambitious. Result reporting depends on the National Ambulatory Medical Care Survey which has had delays in data reporting. Therefore, the date for reporting the 2006 results has been changed from November 2007 to February 2008. Each subsequent year for reporting has also been adjusted.

In FY 2007, the 'Get Smart: Know When Antibiotics Work,' program underwent review by a panel of experts which determined that many of the messages could be expanded. Formative research is now being conducted to begin developing and testing new messages.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 4.2: Protect Americans from death and serious harm caused by medical errors and preventable complications of healthcare.										
4.2.1	Reduce the rate of central line associated bloodstream infections in medical/surgical ICU patients. [O]	3.6 (Met)	Data not available[1]	3.58	2.2 (Exceeded)	3.54	5/2008	3.54	3.54	N/A

[1]The NNIS system transitioned to the NHSN during 2005 and the web-enabled reporting tool was not available until late that year. Specific reporting problems and lack of reporting capability lead to significant under-reporting during that year. Therefore, no results are listed for 2005. These problems were resolved and 2006 data are accurate.

Long Term Objective 4.2, Performance Measure 1:

CDC's efforts to reduce and eliminate healthcare-associated infections are the focus of this measure. CDC has provided leadership in preventing central-line bloodstream infections by developing guidelines for the prevention of these infections, through technical assistance to organizations and state health agencies to implement these guidelines, and in working with CMS to implement Hospital Acquired Conditions rules related to bloodstream infections. CDC

oversees the National Healthcare Safety Network (NHSN), the source of the data provided and a surveillance system currently being used or considered by 14 states that mandate public disclosure of healthcare-associated infections data. The NHSN has been implemented in all hospitals in seven of the fourteen states (California, Colorado, Connecticut, New York, South Carolina, Tennessee, Vermont) as part of state laws requiring reporting of healthcare-associated infections. Through this network, CDC is monitoring infections (including central-line associated bloodstream infections), antimicrobial resistance, and other adverse events in hospitals around the country.

In 2006, results from the NHSN reported a rate of 2.2 infections per 1000 central line-days which exceeded its target of 3.58 infections per 1,000 central line-days. With only one year of data available from the NHSN, CDC must wait for future results to determine trends.

HEALTH PROMOTION

CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS

The Chronic Disease Prevention, Health Promotion, and Genomics program underwent the PART review process in 2006 in preparation for the FY 2008 President's Budget. As a result, many performance measures have been retired and new goals and measures approved through the PART process have been added.

#	Efficiency Measure	FY 2004 Actual	FY 2005 Actual	FY 2006	FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Actual	Target	Actual			
5.E.1	Number of financial actions (such as project carryover funds requests from grantees and grantee project re-budgetings) that delay the implementation of grantee and partners' activities.	N/A	466 (Baseline)	N/A	443	1/2008	419	406	N/A

Efficiency Measure 5.E.1:

This is a new measure for CDC. In FY 2005, 466 financial actions delayed the implementation of grantee and partners' activities. Data for FY 2007 will be available in early 2008.

Approximately 85 percent of CDC's National Center for Chronic Disease Prevention and Health Promotion's (NCCDPHP) budget is spent on extramural funding of grantees and cooperative agreement partners, especially state health departments. These grantees and partners utilize funding to conduct interventions that directly impact the health of the nation. Any delay in receipt of funding results in reduction of the number or duration of the interventions, which, in turn, affects the health impact of our grantees' activities.

Based on recent implementation of a Project Officer training course, increased use of Management Information Systems to track these actions, and increased emphasis on technical assistance, the program will decrease these budget actions each year.

CANCER PREVENTION & CONTROL

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 5.1: Reduce death and disability due to cancer.										
5.1.1	Reduce the age-adjusted annual rate of breast cancer mortality per 100,000 female population. [O]	24.2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	21.3 (FY 2015)
5.1.2	Increase the percentage of women age 40+ who have had a mammogram within the previous two years. [O] [1]	74.6%	N/A	N/A	76.6%	N/A	N/A	77%	N/A	78% (FY 2010)
5.1.3	Decrease the age-adjusted rate of invasive cervical cancer per 100,000 women ages 20+ screened through the NBCCEDP (excludes	17 Baseline	15	N/A	N/A	14	2/2009	14	14	N/A

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
	invasive cervical cancer diagnosed on the initial program screen). [O]									

[1]Source for Measure 5.1.2 is the Women's Health Module of the Behavioral Risk Factor Surveillance System. The data from this module are collected throughout the nation in even years.

Within its 68 funded programs (states, tribes/tribal organizations and U.S. territories), the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides free or low-cost breast and cervical cancer screening and diagnosis to low-income, uninsured, and underinsured women, with special attention to women 50-64 years of age, women who have not been screened within the last five years or more and certain racial and ethnic minority groups.

In addition to funding 68 programs, CDC works with an array of partners, including the American Cancer Society, Avon Foundation and Susan. G. Komen for the Cure, to increase access to breast and cervical cancer early detection and treatment services, develop effective strategies to improve rescreening rates among women enrolled in the NBCCEDP, and implement proven public education and outreach strategies to improve access to screening for women who have rarely or never been screened.

The program's NBCCEDP contributes to the achievement of the following measures by improving access to and the quality of breast and cervical cancer screening and early detection services nationwide.

Long Term Objective 5.1, Performance Measure 1:

This is a new, long term measure for CDC. Data from 2004 shows an age-adjusted rate of 24.4 breast cancer deaths per 100,000 female population, an eight percent improvement from 1999, the baseline year for this measure when the age-adjusted rate was 26.6 deaths per 100,000.

The national screening program has contributed to the notable decline, in recent years, in breast and cervical cancer deaths by providing access to screening services, increasing breast and cervical cancer awareness and education, and inherently changing health-seeking behaviors in women for whom screening services are not otherwise available or accessible.

Long Term Objective 5.1, Performance Measure 2:

This is a new annual measure for CDC. Baseline data from 2004 shows the percentage of women age 40+ who received a mammogram within the previous two years as 74.6 percent.

Timely mammography screening among women aged 40 years or older is the best available method to detect breast cancer in its earliest, most treatable stage, and could reduce breast cancer mortality by approximately 16 percent to 30 percent compared with women who are not screened. In FY 2006, the most recent data reported, the NBCCEDP 1) screened 380,719 women for breast cancers, 2) detected 4,013 breast cancers and 3) provided breast cancer screening to an estimated 14.7 percent of all American women eligible to receive breast cancer screening in the NBCCEDP.

In FY 2006, the percentage increased to 76.6, demonstrating considerable progress toward achieving the FY 2008 target of 77 percent. The NBCCEDP focuses its efforts on reaching those women who are most likely to need assistance with gaining access to, and affording screening services. The national screening program has contributed to the notable decline, in recent years, in breast and cervical cancer deaths by providing access to screening services, increasing breast and cervical cancer awareness and education, and inherently changing health-seeking behaviors in women for whom screening services are not otherwise available or

accessible. Further, CDC is aiming to increase the percentage of mammograms in women 40+ to 78 percent in FY 2010.

Based on annual rates of increase in the 1990's, and the recent leveling-off of the increase in mammography use since the late 1990's, these projected increases will be challenging.

Long Term Objective 5.1, Performance Measure 3:

This measure improved from 17 per 100,000 in 2004 to 15 per 100,000 in 2005, and it applies only to women screened through the NBCCEDP.

In FY 2006, the NBCCEDP 1) screened 367,200 women for cervical cancer using the Pap test; 2) found 5,162 high-grade and invasive cervical lesions; and 3) screened an estimated 6.7 percent of all American women eligible to participate in the NBCCEDP for cervical cancer.

According to the Annual Report to the Nation on the State of Cancer in the US, incidence rates of invasive cervical cancer have declined since 1975, with an average 3.7 percent decline each year since 1996. This decline has occurred in all racial and ethnic groups, including white, black, Asian and Pacific Islander, and Hispanic women.

TOBACCO

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 5.2: Reduce death and disability among adults due to tobacco use.										
5.2.1	Reduce the age-adjusted annual rate of trachea, bronchus, and lung cancer mortality per 100,000 population. [O]	53.2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	43.3 (FY 2010)
5.2.2	Reduce per capita cigarette consumption in the U.S. per adult age 18+. [O][1]	1,814 (Baseline)	1,716	N/A	N/A	1,656	6/2009	1,606	1,558	N/A

[1]Baseline data has been revised. See narrative for rationale.

Long Term Objective 5.2, Performance Measure 1:

This is a new long term measure for CDC. The age-adjusted trachea, bronchus, and lung cancer mortality rate per 100,000 people dropped from 54.1 in 2003 to 53.2 in 2004. Prior to the baseline year of FY 2003, mortality rates from lung cancer were decreasing steadily.

A substantial body of research demonstrates that comprehensive state tobacco control programs reduce smoking-attributable mortality, smoking prevalence, smoking initiation, and cigarette consumption. Recent research shows that the more states spend on comprehensive tobacco control programs, the greater the reductions in smoking, and that the longer states invest in such programs, the greater and faster the impact.

CDC directs and manages the National Tobacco Control Program and other extramural activities to address tobacco use. CDC also provides and supports training and technical assistance to all 50 states, the District of Columbia, territories, national networks, and tribal support centers. CDC will continue to link science and practice and provide leadership to build and sustain tobacco control capacity.

To this end, CDC prepared *Best Practices for Comprehensive Tobacco Control Programs—2007*. This guidance document, which updates the 1999 original, describes an integrated state budget structure for implementing interventions proven to be effective. CDC will continue to support *Best Practices for Comprehensive Tobacco Control Programs—2007*, reflecting

additional state experiences in implementing comprehensive programs and new scientific literature since its original release in 1999.

CDC will continue to advance the science base of tobacco control by conducting and coordinating research, surveillance, and evaluation activities related to tobacco and its impact on health. CDC synthesizes and translates research into practice; disseminates scientific findings; and provides technical assistance to states, territories, national networks, tribal support centers, and the general public.

Long Term Objective 5.2, Performance Measure 2:

This is a new measure for CDC. Per capita cigarette consumption for adults age18+ has fallen from the baseline 1,814 in 2004 to 1,716 in 2005. The original baseline for this measure was 1,770. In a subsequent Tobacco Outlook Report, the U.S. Department of Agriculture revised the data for 2004 because of Census adjustments. Therefore, CDC's tobacco program revised its baseline and targets accordingly.

CDC supports the National Tobacco Prevention and Control (NTCP) program in 50 states and the District of Columbia. NTCP grants support state, local and territorial health department efforts to prevent initiation of tobacco use among youth and young adults, promote tobacco use cessation among adults and youth, eliminate exposure to secondhand smoke, and identify and eliminate tobacco-related disparities.

CDC supports the National Network of Tobacco Use Cessation Quitlines, a collaborative effort between CDC, the National Cancer Institute's (NCI) Cancer Information Service (CIS), the North American Quitline Consortium (NAQC), and state tobacco control programs through 1-800-QUIT-NOW.

CDC provides technical assistance and training to help states plan, establish, and evaluate their own tobacco control programs.

CDC responds to approximately 50,000 scientific, technical and public inquiries on tobacco use each year. The program also provides advertising materials to states through the Media Campaign Resource Center.

Since 1964, the U.S. Surgeon General's reports on smoking and health have concluded that smoking is a primary cause of lung cancer. Achieving the targets of this measure therefore supports the goal of reducing death and disability due to lung cancer.

DIABETES

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 5.3: Prevent diabetes and its complications.										
5.3.1	Maintain the age-adjusted rate of incidence of End-Stage Renal Disease (ESRD) per 100,000 diabetic population at no higher than its current rate. [O]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	231.7 (FY 2010)
5.3.2	Increase the age-adjusted percentage of persons with diabetes age 18+ who receive an A1C test at least two times per year. [O]	68.8%	64%	N/A	68%	72%	12/2008	73%	74%	N/A

CDC's primary functions as related to diabetes are as follows:

1. Define the diabetes burden through the use of public health surveillance.
    - CDC seeks to strengthen public health surveillance systems for diabetes. The program primarily works with states using several national data sources including the Behavioral Risk Factor Surveillance System (BRFSS) to maintain a nationwide, state-based surveillance system.
2. Conduct applied translational research.
    - CDC conducts applied translational research that focuses on translating research findings into clinical and public health practice. This research identifies and details the public health implications of results from clinical trials and scientific studies and effectively applies these findings in the health care system and in communities.
3. Develop and maintain state-based diabetes and prevention programs.
    - CDC provides funding for state-based diabetes prevention and control programs (DPCPs) in all 50 states, the District of Columbia, and 8 current and former U.S. territories. DPCPs place an emphasis on reaching high-risk and disproportionately affected populations.
4. Support the National Diabetes Education Program.
    - The National Diabetes Education Program (NDEP) is a joint initiative sponsored by CDC and the National Institutes of Health (NIH). The NDEP is designed to improve treatment and outcomes for people with diabetes, promote early diagnosis, and prevent the onset of type 2 diabetes.

Long Term Objective 5.3, Performance Measure 1:

This is a new long term measure for CDC.

End Stage Renal Disease (ESRD) is a complicated and disabling condition and one of the most expensive conditions for which the federal government provides financial coverage. Diabetes mellitus is presently the most common cause of ESRD in the U.S., accounting for approximately 45 percent of all cases of ESRD.

For decades, ESRD incidence was increasing. Since the late 1990's, the rates have declined. The 2002 baseline rate is 231.7 per 100,000 people with diabetes. As those with diabetes live longer, the incidence of ESRD is likely to increase. Therefore, CDC aims to maintain the current baseline rate.

CDC's diabetes program works to eliminate the preventable burden of diabetes through leadership, research, programs, and policies that translate science into practice. CDC's diabetes activities are based on the prevailing science for diabetes prevention and control which demonstrates that many of the serious diabetes-related complications, including ESRD, may be prevented.

Long Term Objective 5.3, Performance Measure 2:

This is a new measure for CDC. Since the baseline year 2004, the percentage of A1C testing in this population has fluctuated from 68.8 percent to 64 percent in 2005, and back up to 68 percent in 2006. As the number of people with diabetes continues to increase, and as those with diabetes live longer, the targets for this measure will be increasingly challenging to meet.

Glucose control is one important pathophysiologic factor in the genesis of ESRD and other complications from diabetes. As A1C measurement is the best indicator of glucose control, the

annual measure of A1C relates closely to the likelihood of achieving the long term measure of controlling the rate of ESRD and other complications among persons with diabetes.

CDC aims to increase the age-adjusted proportion of persons with diabetes who receive two or more A1C tests by one percentage point every year.

CDC's Diabetes program works to eliminate the preventable burden of diabetes through leadership, research, programs, and policies that translate science into practice. CDC's diabetes activities are based on the prevailing science for diabetes prevention and control which demonstrates that many of the serious diabetes-related complications, including ESRD, may be prevented.

HEART DISEASE AND STROKE

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 5.4: Reduce death and disability due to heart disease and stroke.										
5.4.1	Reduce the age-adjusted annual rate per 100,000 population of coronary heart-disease and stroke-related deaths. [O][1]	CHD: 150 Stroke: 50	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CHD: 166 Stroke: 50 (FY 2015)
5.4.2	Increase the age-adjusted proportion of persons age 18+ with high blood pressure who have it controlled (<140/90). [O][2]	36% (Unmet)	N/A	41%	12/2008	N/A	N/A	50%	N/A	59% (FY 2010)
5.4.3	Maintain the age-adjusted proportion of persons age 20+ with high total cholesterol (>=240mg/dL) at no higher than its current rate. [O] [2]	18% (Unmet)	N/A	17%	12/2008	N/A	N/A	17%	N/A	17% (FY 2010)

[1]The baseline for this measure was actually provided in FY 2000, not FY 2002 as previously reported.
[2]This measure reports NHANES data spanning a two year period. For example the FY 2004 data actual covers calendar years 2003 and 2004.

Long Term Objective 5.4, Performance Measure 1:

This is a new long term measure for CDC. Rates for 2004 were 150 per 100,000 population for heart disease deaths, and 50 per 100,000 population for stroke-related deaths. This is an improvement from the 2000 baseline of 187 and 61, and shows the out-year target met for stroke-related deaths.

Coronary heart disease (CHD) death rates have been decreasing steadily since 1995. Stroke rates have been fairly stable since 1998.

CDC provides states with financial and programmatic assistance to develop, implement, and evaluate cardiovascular disease prevention and control programs. CDC supports achievement of the target for heart disease and stroke prevention in its four distinct but complementary parts: 1) prevention of risk factors; 2) detection and treatment of risk factors; 3) early identification of heart attacks and strokes; and 4) prevention of recurrent cardiovascular events. To reach this goal, CDC's heart disease and stroke prevention efforts include the implementation of science-based public health programs, research and surveillance activities, the development and application of evaluation procedures, the development of tools to be used by states and communities, expanding partnership initiatives, and addressing health disparities.

Heart disease and stroke prevention activities focus on adults and older adults, with special attention given to higher-risk populations. The program also carries out the Mississippi Delta Health Initiative and is continuing a partnership with the Indian Health Service to address heart disease and stroke prevention among rural American Indians/Alaska Natives.

Heart disease and stroke prevention activities include:

1. **State Heart Disease and Stroke Prevention Programs**, funded since 1998 through cooperative agreements awarded competitively.

- Thirteen states receive funding for Basic Implementation programs. Activities for these programs include implementing population-based interventions that address priority populations and settings.
- Twenty-one states and the District of Columbia receive funding for Capacity Building programs, which prepares these states for program implementation through such activities as identifying priority populations and developing a comprehensive State Plan. Capacity Building funding helps state health departments develop the human and technical capacity to properly address heart disease and stroke.
- The Heart Disease and Stroke Prevention Program has identified high-impact points of intervention to stem the tide of cardiovascular disease. Because of continuing public health and clinical efforts, age-adjusted death rates continue to drop for both ischemic heart disease and stroke.

2. The **Paul Coverdell National Acute Stroke Registry**, funded since 2001, competitively funds states through cooperative agreements to measure, track, and improve the quality and delivery of stroke care. Six states are currently funded.

- All states funded by the Coverdell Registry during FY 2003-2006 have initiated or adopted statewide stroke care legislation to reduce mortality and otherwise improve patient outcomes.

3. There are many **other CDC heart disease and stroke prevention-related activities**, including surveillance and epidemiologic studies, applied research, and evaluation projects:

- Monitoring and Surveillance – CDC helps states and communities track trends in heart disease and stroke and their risk factors. By analyzing and publicizing this data, public health strategies can be better developed and implemented according to recognized health needs. For the first time ever, in 2007 CDC was able to report the state-by-state prevalence rates of both heart disease and stroke.
- Translating the science into practice – CDC engages in applied research and research translation to support sound, evidence-based practice in heart disease and stroke prevention. From its research, CDC develops and disseminates many products and tools that cardiovascular disease prevention programs can use and apply in various public health settings. Many tools and resources are available on the web.
- Evaluation – CDC not only provides technical assistance to help states evaluate their programs, it also works at the cutting edge of evaluation research in heart disease and stroke prevention.

Long Term Objective 5.4, Performance Measure 2:

This is a new measure for CDC. In 2004, 36 percent of adults age 18+ with high blood pressure had it controlled. Prior to 2000, data for this measure was collected sporadically. Before this was a performance measure for CDC, rates increased from 32 percent in 2000 to 36 percent in 2004. Continuing emphasis on this measure should improve performance even further.

The relationship between blood pressure and the risk of Cardiovascular Disease (CVD) events is consistent and independent of other factors. The higher the blood pressure, the greater is the chance of heart attack, heart failure, stroke, and kidney disease. About 69 percent of people who have a first heart attack, 77 percent who have a first stroke, and 74 percent who have congestive heart failure also have hypertension.

CDC funds thirty-four State Heart Disease and Stroke Prevention Programs. CDC's Heart Disease and Stroke Prevention Program has identified high-impact points of intervention to stem the tide of cardiovascular disease. Controlling high blood pressure is a priority. Almost 90 percent of middle-age Americans will develop high blood pressure in their lifetime. Controlling high blood pressure is very important, as a 12 to 13 point drop in high blood pressure can reduce cardiovascular disease deaths by 25 percent. Control of high blood pressure appears to be improving, with 36 percent of all hypertensive American adults controlling their blood pressure in 2003-2004, up from 32 percent at the turn of the century. However, this indicates that in the most recent comprehensive figures, nearly 65 percent of those with high blood pressure still did not have it under control.

Long Term Objective 5.4, Performance Measure 3:

This is a new measure for CDC. Since the baseline for the measure was established at 17 percent (actually 17.3 percent) for the period 1999 to 2002, the rate for 2004 rose slightly to 17.6 percent, rounded to 18 percent. In the last several years, the prevalence of high cholesterol among U.S. adults has remained at approximately 17 to 18 percent.

Approximately 38 million American adults have blood cholesterol levels of 240 mg/dL or higher, which is considered high risk. Lowering cholesterol can reduce the risk for developing heart disease, including heart attacks, and, among those with heart disease, the need for heart bypass surgery or angioplasty. Recent studies show that high levels of LDL ("bad" cholesterol) and triglycerides increase the risk of stroke in people with previous coronary heart disease, ischemic stroke or transient ischemic attacks. Low levels of HDL ("good" cholesterol) may also raise stroke risk.

CDC funds 34 State Heart Disease and Stroke Prevention Programs. CDC's Heart Disease and Stroke Prevention Program has identified high-impact points of intervention to stem the tide of cardiovascular disease. Addressing cholesterol is a priority.

The estimate for this measure is expected to increase with the emerging epidemic of obesity. Therefore, it will be challenging for CDC to keep the rate in the 17 to 18 percent range.

NUTRITION AND PHYSICAL ACTIVITY

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 5.5: Reduce the rate of growth of obesity through nutrition and physical activity interventions.										
5.5.1	Reduce the age-adjusted percentage of adults age 18+ who engage in no leisure-time physical activity. [O]	24.36%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	21.5% (FY 2014)
5.5.2	Slow the estimated average age-adjusted annual rate of increase in obesity rates among adults age 18+. [O]	+0.64 average increase per year	N/A	N/A	N/A	N/A	N/A	N/A	N/A	+0.16 average increase per year (FY 2014)

CDC's Nutrition, Physical Activity, and Obesity Program also uses the following impact objectives to support this measure:

- Increase the number, reach, and quality of policies and standards set in place to support healthful eating and physical activity in various settings.
- Increase access to and use of environments to support healthful eating and physical activity in various settings.
- Increase the number, reach and quality of social and behavioral approaches that complement policy and environmental strategies to promote healthful eating and physical activity.

Long Term Objective 5.5, Performance Measure 1:

This is a new long term measure for CDC. In FY 2004, CDC reported that 24.36 percent of adults age 18+ engage in no leisure-time physical activity. There has been an absolute decline from 29 to 24 percent in the past ten years. Rate of decrease is expected to lessen over the next ten years.

Major causes of morbidity and mortality in the U.S. are related to physical inactivity and poor diet. In particular, CVD, type two diabetes, hypertension, and certain cancers are linked to poor diet and a sedentary lifestyle.

The aforementioned program objectives which support this PART measure will be accomplished by promoting and assisting states with the following policy and environmental strategies which will increase the number of physical activity interventions that are implemented and evaluated in funded states:

- Physical Activity Incentives/Disincentives
- Recreation
- Transportation
- Land Use/Design
- Safety (as a barrier to physical activity)

The program has accomplished its impact objectives through drastic increases in the number of intervention implemented and evaluated in funded states. These interventions include policies and standards, environmental changes, and social and behavioral approaches.

Policy promotion and environmental changes are of strategic importance because of the power that these approaches have not only in changing individual health behaviors, but also in creating healthy environments and norms that can support these behaviors.

Long Term Objective 5.5, Performance Measure 2:

This is a new long term measure for CDC. CDC intends to reduce the rate of growth of obesity through nutrition and physical activity interventions. CDC has gathered baseline data for measures relating to obesity rates. In FY 2004, CDC reported that the estimated average age adjusted annual rate of increase in obesity rates among adults 18+ was 0.64 between FY 2002 and FY 2004. CDC plans to slow the rate of increase from 0.64 percent per year to 0.16 percent per year.

About 60 million adults, or 30 percent of the adult population, are now obese. Obesity is related to two-thirds of diabetes cases and heart disease cases, 20 percent of cancers in women and 15 percent of cancers in men. Additionally, it causes or exacerbates many other serious chronic diseases and conditions, including hypertension and stroke.

The aforementioned program objectives which support this PART measure will be accomplished by promoting and assisting states with the following policy and environmental strategies which will increase the number of physical activity interventions that are implemented and evaluated in funded states:

- Food Availability
- Food Advertisement/Promotion
- Food and Physical Activity Incentives/Disincentives
- Recreation
- Transportation
- Land Use/Design
- Safety (as a barrier to physical activity)

The program has accomplished its impact objectives through drastic increases in the number of interventions implemented and evaluated in funded states (output table). These interventions include policies and standards, environmental changes, and social and behavioral approaches.

Promoting regular physical activity and healthy eating by creating policies and an environment that support these behaviors is essential to reducing the epidemic of obesity. The National Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases is the mechanism by which states are supported in accomplishing these tasks to slow the progression of obesity and other chronic diseases.

Given that the prevalence of obesity has been increasing since the late 1960's, an overnight, one-size-fits-all solution to the obesity epidemic is not likely. Rather, the solutions will need to be strategic and sustained, will require input and change at many levels, across many sectors of society, and across all settings in which people live, work, learn, and play.

SCHOOL HEALTH

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 5.6: Improve youth and adolescent health by helping communities create and environment that fosters a culture of wellness and encourages healthy choices.										
5.6.1	Achieve and maintain the percentage of high school students who are taught about HIV/AIDS prevention in school at 90% or greater. [O] [1]	N/A	87.9% (Baseline)	N/A	N/A	90%	6/2008	N/A	90%	N/A
5.6.2	Increase the proportion of adolescents (grades 9-12) who abstain from sexual intercourse or use condoms if currently sexually active. [O] [1]	N/A	87.5% (Baseline)	N/A	N/A	89%	6/2008	N/A	89%	N/A
5.6.3	Reduce the proportion of children aged 3 to 11 who are exposed to second-hand smoke. [O] [2]	N/A	N/A	N/A	N/A	N/A	N/A	45%	N/A	45% (2010)
5.6.4	Percentage of youth (grades 9-12) who were active for at least 60 minutes per day for at least five of the preceding seven days. [O]	N/A	35.8%	N/A	N/A	35.8%	6/2008	N/A	35.8%	N/A

[1] The data source for these measures is the Youth Risk Behavior Surveillance System, which is conducted in odd years.
[2] This measure reports NHANES data spanning a two-year period. For example, the FY 2008 data actually covers calendar years 2007 and 2008.

Long Term Objective 5.6, Performance Measures 1 and 2:

In 2004, an estimated 7,761 young people were living with AIDS, a 42 percent increase since 2000, and an estimated 3,867 young people received a diagnosis of HIV/AIDS, representing about 12 percent of the persons given a diagnosis during that year. Young men who have sex with men, especially those of minority races or ethnicities, were at high risk for HIV infection.

Additionally, each year there are approximately 19 million new STD infections in the U.S. and almost half of them are among youth ages 15 to 24. Thirty-four percent of young women – approximately 820,000 each year – become pregnant at least once before the age of 20. Data from the 2005 Youth Risk Behavior Survey (YRBS) show that 47 percent of high school students had had sexual intercourse, 14 percent of high school students had four or more sex partners during their lifetime, and 37 percent of sexually active high school students did not use a condom during last intercourse. STDs (including HIV) among youth result in substantial economic burden to our society. The total estimated burden of the nine million new cases of STDs that occurred among 15 to 24-year-olds in 2000 was $6.5 billion (in year 2000 dollars).

School health programs play a unique and important role in the lives of young people by improving their health knowledge, attitudes and skills, health behaviors and outcomes, educational outcomes, and social outcomes. CDC emphasizes a coordinated, comprehensive, and collaborative approach to school health. It focuses on strengthening the health infrastructure of state and local education agencies and schools to address critical health issues including obesity, asthma, and HIV, STD, and teen pregnancy prevention, by building the capacity of funded partners to support science-based, cost-effective health programming. In the long term, the program aims to reduce the rates of chronic diseases, and HIV, other sexually transmitted diseases, and teen pregnancy through the following activities:

- Monitoring priority health risk behaviors and school health programs and policies through systems such as the Youth Risk Behavior Surveillance System, the School Health Policies and Programs Study, and School Health Profiles;
- Analyzing research findings to develop guidelines for addressing priority health risk behaviors among students and developing tools such as the *School Health Index: A Self-Assessment and Planning Guide*, to help schools implement these guidelines;
- Enabling states, cities, and national organizations to develop, implement, and evaluate their own school health programs to improve the health, education, and well-being of young people;
- Evaluating the impact of interventions to improve programs; and
- Implementing Healthy Passages, a longitudinal study designed to provide a scientific basis for the development of policies and interventions to help keep children and adolescents healthy. This study will characterize the relative contribution of important factors that influence behaviors and outcomes over time.

A cost effectiveness study revealed that for every dollar invested in school HIV, STD, and pregnancy prevention efforts, $2.65 in medical and social costs were saved.

In FY 2009, CDC intends to fund 49 states and up to two tribes to support HIV prevention activities in schools. CDC currently funds 48 state education agencies, 18 local education agencies and seven territorial education agencies to implement HIV prevention activities in secondary schools, post-secondary institutions, and settings that serve youth in high-risk situations.

In FY 2005, the percentage of high school students who were taught about HIV/AIDS prevention in schools was 87.9 percent, which was equal to the rate in 2003, but less than the 89 percent rate in 2001. For the same year, the proportion of adolescents (grades 9-12) who abstained from sexual intercourse or used condoms if currently sexually active was 87.5 percent. This was equal to the 2003 rate and an improvement over the 2001 rate of 86 percent.

Long Term Objective 5.6, Performance Measure 3:

This is a new measure for CDC.

In 2002, 55 percent of children age three to 11 were exposed to secondhand smoke. Prior to the baseline time period, this indicator was declining steadily, with significant progress between the end of NHANES III (1988-1994) and the most recent NHANES (1999-2002).

Secondhand smoke, also known as environmental tobacco smoke (ETS), has been determined to be a known human carcinogen. Persistent exposure to ETS is associated with an increased risk for lung cancer. Since 1986, U.S. Surgeon General's reports have concluded that exposure to secondhand smoke causes lung cancer in nonsmokers.

Through the National Tobacco Control Program (NTCP), CDC provides national leadership for a comprehensive, broad-based approach to reducing tobacco use which involves: preventing young people from starting to smoke; eliminating exposure to secondhand smoke; promoting quitting; and, identifying and eliminating disparities in tobacco use among population groups. It also develops health communication campaigns aimed at informing the public about the health risks associated with ETS and reducing disparities in these exposures.

On September 18, 2007, CDC, working closely with the Office of the Surgeon General, launched two major collaborative national initiatives to protect children from exposure to secondhand smoke. During the event, Acting Surgeon General Kenneth Moritsugu released an

excerpt summarizing key scientific evidence on the serious health risks that secondhand smoke poses to children.

The publication, *Children and Secondhand Smoke Exposure*, is excerpted from the 2006 Surgeon General's Report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke*. In addition, the Acting Surgeon General announced a new partnership with the American Academy of Pediatrics that will mobilize pediatricians and other primary care clinicians to help parents reduce their children's exposure to secondhand smoke.

That same day, CDC staffed a meeting of the Interagency Committee on Smoking and Health, an advisory committee chaired by the Surgeon General and intended to foster greater collaboration among federal government agencies on tobacco control initiatives. The meeting identified several areas of future collaboration including the development and dissemination of targeted materials for pediatricians as well as outreach to other primary care organizations.

CDC is working closely with EPA and ACF's Office of Head Start to support the implementation of the *Care for Their Air* initiative.

CDC continues to extend and maximize the impact of the 2006 Surgeon General's Report on *The Health Consequences of Involuntary Exposure to Tobacco Smoke* by collaborating with its partners to publish and present studies expanding the science base on secondhand smoke, to work with the news media to keep secondhand smoke in the news, to provide technical assistance to states as they implement and evaluate smoke-free laws, and to disseminate information on the report and ancillary materials to a wide range of partners and stakeholders.

Long Term Objective 5.6, Performance Measure 4:

This is a new measure for CDC. In 2005, 38.5 percent of youth (grades 9-12) were active for at least 60 minutes per day for at least five of the preceding seven days. Prior to 2005, this data was not collected by the Youth Risk Behavior Surveillance System (YRBSS). The guideline for this measure was developed and published in FY 2005.

Increased physical activity, whether through structured (e.g., organized recreation or sports) or unstructured (e.g., recess, free play) opportunities, helps reduce the risk of chronic diseases and prevents excess weight gain among children and adolescents. Physical activity is a critical component of obesity prevention efforts, as those adolescents who are already overweight are at an increased risk of 70 percent of becoming overweight and obese adults. Chronic diseases and obesity in adulthood are even more likely if overweight existed in adolescence, thereby increasing the likelihood of adults suffering from multiple co-morbidities, such as heart disease, type 2 diabetes, and certain types of cancer.

CDC supports the following in its programs for achieving the targets for this measure:

- **Funding State Programs –** CDC currently funds 23 state education agencies to establish a partnership with their state health agency to focus on reducing chronic disease risk factors such as tobacco use, poor nutrition, and physical inactivity. These programs emphasize collaboration across health and education sectors, institutionalization of a comprehensive, systematic approach to improving health and education outcomes, and implementation of policies and programs that are scientifically sound and evidence-based.

- **Capacity Building through National Non-Governmental Organizations (NGOs)** – CDC funds 29 national non-governmental organizations (NGOs) to build the capacity of societal institutions that influence youth. These organizations implement activities that are directed toward building the capacity of CDC funded state, territorial, and large local school district programs, youth serving organizations, and other NGOs. The activities

involve intensive training, follow-up support and technical assistance, and evaluation to fully integrate and sustain programs that promote healthy behaviors for the nation's youth.

- **Monitoring Activities –** CDC monitors priority health risk behaviors and school health programs and policies through the following systems: The Youth Risk Behavior Surveillance System (YRBSS) provides national, state, and local level data on the prevalence of six categories of priority health risk behaviors which include: tobacco use; unhealthy dietary behaviors; inadequate physical activity; sexual behaviors that may result in HIV infection, other sexually transmitted diseases, and teen pregnancies; alcohol and other drug use; and behaviors that contribute to unintentional injury and violence; the School Health Profiles helps state and local education and health agencies monitor the current status of school health education; school health policies related to HIV infection/AIDS, tobacco use prevention, unintentional injuries and violence, physical activity, and food service; physical education; asthma management activities; and family and community involvement in school health programs; the School Health Policies and Programs Study (SHPPS) is a national survey periodically conducted to assess school health policies and programs at the state, district, school, and classroom levels.
- **Guidelines and Tools for Schools –** CDC synthesizes research findings to identify policies and practices that are most likely to be effective in promoting healthy behaviors among young people. Research-based recommendations for school health programs are featured in a series of publications called the CDC guidelines for school health programs. To date, these guidelines have addressed tobacco-use prevention, promotion of healthy eating and physical activity, prevention of unintentional injuries and violence, skin cancer prevention, and AIDS education.

The guidelines are developed on the basis of an exhaustive review of published research and input from academic experts and national, federal, and voluntary organizations interested in child and adolescent health. Recommendations cover topics such as policy development, curriculum development and selection, instructional strategies, staff training, family and community involvement, evaluation, and linkages between different components of the coordinated school health program.

CDC applies research by developing tools to help practitioners in the field implement research synthesis recommendations. Examples of these tools include:

- The School Health Index: A Self-Assessment and Planning Guide.
- Fit, Healthy, and Ready to Learn: A School Health Policy Guide, developed by the National Association of State Boards of Education with CDC support.
- The Physical Education Curriculum Analysis Tool, a tool to enable educators to evaluate physical education curricula.

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

The Birth Defects and Developmental Disabilities program underwent PART process in FY 2006 in preparation for the FY 2008 President's Budget. As a result, several of the performance budget measures have been changed or retired, while new measures approved through the PART process have been added. All measures included in the performance plan are PART measures.

#	Efficiency Measure	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
6.E.1	Increase the percent of competitive (new) cooperative agreements/grants that are processed in less than or equal to 176 days (excluding extramural research). [E]	N/A	64% (Baseline)	73%	0% (Unmet)	82%	0% (Unmet)	91%	91%	N/A

Efficiency Measure 6.E.1:

In 2006, Efficiency Measure 6.E.1 was established for PART and sought to achieve a target 73 percent of new competitive cooperative agreements/grants processed in less than or equal to 176 days (excluding extramural research). In FY 2006, only one new award was accomplished in 193 days under this measure and did not meet the Key Performance Indicator target due to discussions on eligibility language between Program and the Procurement and Grants Office (PGO). The Extramural Program Management Information System (EPMIS) does not track the details on delays in the Request for Applications process. There are several time intervals on the modification phases to the draft before it becomes final with comments and feedback from PGO before actual publishing date.

A corrective measure would be to track the process manually with dates of each amendment or discussion with PGO in the RFA process until publication. Along with the manual tracking process, a program modification will be implemented to the current EPMIS system to allow tracking of all the interval steps of the review process. It is also recommended that the PART measure be amended to include all awards and not limited to new competitive non-research awards.

BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 6.1: Prevent birth defects and developmental disabilities.										
6.1.1	Increase the sensitivity of birth defects and developmental disabilities monitoring data. [O]	N/A	Yes (Met)	Developmental Disabilities-Enroll 40-50% of eligible sample	Yes (Met)	Birth Defects-Establish Baseline/ Developmental Disabilities - Enroll remaining eligible sample	Yes (Met)	Birth Defects-Improve by 1% /Developmental Disabilities-Data analyses and preliminary results	Birth Defects-91% /Developmental Disabilities-Establish baseline sensitivity percentage	N/A

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
6.1.2	Identify and evaluate the role of at least five new factors for birth defects and developmental disabilities.	N/A	Yes (Met)	Finalize research agenda for birth defects and publish findings on smoking, obesity, and other exposures with high potential impact	Yes (Met)	Publish findings on alcohol, caffeine use, and nutrition	Yes (Met)	Publish findings on maternal medications	Publish findings on occupational exposures	N/A
6.1.3	Reduce health disparities in the occurrence of folic acid-preventable spina bifida and anencephaly by reducing the birth prevalence of these conditions among Hispanics. [O]	Target: 5.3 (2/2008)	12/2008	5.0	12/2009	4.9	12/2010	4.8	4.7	N/A
6.1.4	Increase the percentage of health providers who screen women of childbearing age for risk of an alcohol-exposed pregnancy and provide appropriate, evidence-based interventions for those at risk. [O]	Published Recommendations (Met)	Completed RCT (Met)	Develop and disseminate screening and intervention tools for health care providers serving women of childbearing age.	Yes (Met)	Assess the screening and intervention practices of nationally representative samples of provider groups.	Yes (Met)	Implement ongoing provider education programs and establish baseline rates of provider-based screening and intervention.	Increase provider-based screening and intervention by 1% from baseline.	N/A

Long Term Objective 6.1, Performance Measure 1:

Because the birth defects system is more mature and able to be assessed numerically, investments in the developmental disabilities systems are needed to measure the same level (a study was developed in FY 2004 and initiated in FY 2005). However, the model for the birth defects and developmental disabilities surveillance systems is based on the same methodology. For birth defects, the target percentage is a measure of sensitivity. For developmental disabilities, the measure is initially based on establishing the baseline probability that a true developmental disability is identified by the program's model system.

The program is currently wrapping up data cleaning for a Validation Study of our autism surveillance methodology. The study was designed to evaluate sensitivity as well as positive predictive value. Data analysis will be finalized during FY2008 and results will provide baseline estimates. This Validation Study was costly and quite labor intensive and there are currently no plans or funding to replicate the study any time in the near future. Therefore, these baseline estimates are likely to be the only scientifically sound estimate of sensitivity available. It may be possible to implement some crude analytic strategies to explore sensitivity, although additional investments would be required to replicate the findings of our Validation Study.

CDC met its objective by obtaining baseline data during FY 2007 for Birth Defects, and will now be working towards obtaining data in FY 2009 for Developmental Disabilities.

Long Term Objective 6.1, Performance Measure 2:

Understanding the role of modifiable risk and preventive factors in the etiology of birth defects and developmental disabilities provides an important opportunity for prevention. As prior investments in the research infrastructure for birth defects is more mature, initial efforts for annual performance measures focus on publication of research findings from this system. Meanwhile, the infrastructure for research on autism and other developmental disabilities research is being established. This research infrastructure follows the same model as birth defects but is in the early stages of development, with initial publication of findings expected in FY 2012.

In 2007, the National Birth Defects Prevention Study (NBDPS) contributed substantially to the available knowledge about causes for birth defects:

- One study, published in the New England Journal of Medicine, found that the use of certain antidepressants, selective serotonin-reuptake inhibitors, most commonly known as SSRIs, during pregnancy does not significantly increase the risk for most birth defects. This finding includes the risk for congenital heart defects, which were associated with SSRI use in previous studies. Researchers did, however, find associations between SSRI use and three specific birth defects: a defect of the brain, one type of abnormal skull development and a gastrointestinal abnormality. CDC plans to continue to study the association to clarify whether a true risk exists.
- Another paper that will be very helpful to other birth defects researchers details the development of a classification system for congenital heart defects.
- The association between obesity and birth defects has also been described in a 2007 paper using NBDPS data with obese mothers having an increased risk of seven defects including spina bifida, heart defects and limb reduction defects.
- Mothers with thyroid disorder are at an increased risk of having a child with craniosynostosis, a condition where the sutures in an infant's skull close or fuse before

the brain has finished growing. Because the brain is growing normally, it will take the path of least resistance which results in a misshapen head or face.

- Mothers who smoke cigarettes in early pregnancy are more likely to have an infant with an orofacial cleft than mothers who do not smoke.

The project has met its objectives for FY 2007 and anticipates meeting the next year's targets.

Long Term Objective 6.1, Performance Measure 3:

Pregnancies and births affected by spina bifida and anencephaly have profound physical, emotional, and financial effects on families and communities. Since food fortification began in 1998, thousands of babies are born in the U.S. without these serious birth defects. However, analyses by racial and ethnic groups found that while fortification lowered rates significantly among all racial and ethnic groups, a disparity with respect to Hispanics has persisted.

CDC is currently focusing on developing and implementing evidence-based strategies to reduce the occurrence of these birth defects among Hispanics. Targets are based on the concept of diminishing returns, the understanding that preventing the earlier cases was easier than preventing the latter cases. For example, from 1996 to 2000, rates declined by 36 percent. As it became increasingly difficult to prevent cases with existing strategies, more intensive efforts were required to achieve the same level of reductions. Thus, for the next five year period (2001-2005), targets were set based on a proposed 18 percent decline in rates (half of 36 percent). Similarly, for the subsequent five years (2006-2010), CDC set targets based on a proposed decline of an additional nine percent (one-half of 18 percent) from FY 2005.

Unfortunately, data for FY 2003 reveal an increase in the rate of these birth defects among the Hispanic population. The data further underscores the importance of targeted efforts to address the high rates among Hispanics. CDC's two priority activities in this area are developing and disseminating targeted campaign materials and working with partners to explore the addition of folic acid to corn flour products. CDC has just completed formative research with Spanish-speaking Latinas of childbearing age and key gatekeepers who work closely with this audience. Research findings were used to develop new folic acid educational materials and radio public service announcement messages that address the unique needs of this audience. These materials are available for free to the public and health care professionals via CDC's public education clearinghouse. Additionally, CDC continues to explore the impact of folic acid in potentially preventing other birth defects. For example, using data from CDC's birth defects surveillance program, CDC reported findings that diabetic women who consume multivitamins containing folic acid have reduced risk of having a child with diabetes-associated birth defects. These two areas will be given focus in our activities in the coming year. FY 2004 results will be reported for this measure in February 2008.

Long Term Objective 6.1, Performance Measure 4:

Implementing intervention strategies to reduce alcohol consumption during pregnancy is an important component of reducing the occurrence of alcohol-related birth defects and developmental disabilities, including Fetal Alcohol Syndrome (FAS). Research shows that: 1) provider-based screening of women of childbearing age at risk of having an alcohol-exposed pregnancy; and 2) provider-based interventions for women at risk are effective strategies for reducing alcohol-exposed pregnancies. CDC has begun to translate research findings through the development and publication of targeted recommendations on provider-based screening and interventions for women of childbearing age.

CDC has developed a quick-reference clinician tool to facilitate screening and interventions among providers and fetal alcohol prevention toolkits continue to be disseminated. Through

education about and implementation of this tool, CDC aims to improve the percentage of health care providers who screen women of childbearing age for risk of alcohol-exposed pregnancy, and provide appropriate interventions for those at risk. Activities which have allowed CDC to meet its FY 2007 target include the following:

1. Assessing Screening and Intervention Practices of Nationally Representative Samples of Provider Groups

- Currently conducting data analysis on survey of psychiatrists (random sample of 2,000 members of the American Medical Association with a primary specialty of psychiatry or child psychiatry) regarding their knowledge, attitudes and beliefs about fetal alcohol syndrome and alcohol-exposed pregnancies.
- Currently working with ACOG to analyze data from a recent survey of obstetricians-gynecologists (sample of 1,000 ACOG Fellows) regarding their knowledge, attitudes, and practices regarding alcohol use and pregnancy, screening for risky drinking, provision of brief interventions for women at risk for an alcohol-exposed pregnancy, and their awareness and use of the ACOG Fetal Alcohol Spectrum Disorders (FASD) Prevention Tool Kit.
- Plans are underway to conduct a survey of practicing family physicians (sample of 1,000 from the American Academy of Family Physicians).

2. Ongoing Provider Education

- The four FASD Regional Training Centers (RTCs) continue to train medical and allied health students and practitioners regarding alcohol use and pregnancy and the identification of women at risk for an alcohol-exposed pregnancy, as well as individuals with prenatal alcohol exposure. Reaching medical and allied health students and practitioners continues to be a priority of the FAS Prevention Team and efforts are underway to ensure continued work in this area.
- A core curriculum developed by the RTCs, CDC, and the National Organization on Fetal Alcohol Syndrome will be released in 2008.
- The important work of the FASD RTCs was published in the *American Journal of Health Education* in its November/December 2007 issue.

HEREDITARY BLOOD DISORDERS/HUMAN DEVELOPMENT AND DISABILITIES

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 6.2: Improve the health and quality of life of Americans with disabilities.										
6.2.1	Increase the number of people with blood disorders who participate in the monitoring system by 10%[O]	N/A	17,874 (Baseline)	18,232	19,889 (Exceeded)	18,590	21,760 (Exceeded)	18,948	19,306	Increase by 10% (FY 2010)
6.2.2	Identify an effective public health intervention to ameliorate the effects of poverty on the health and well-being of children. [O]	Baseline data collected	Data collected and analyzed for age 6 months	Data collection and analysis for age 1 year	Yes (Met)	Data collection and analysis for age 2 year	Yes (Met)	Data collection and analysis for age 3 year	Data collection and analysis for age 4 year	N/A
6.2.3	Ensure that 95% of all infants are screened for hearing loss by 1 month of age. [O]	92% (Exceeded)	92% (Exceeded)	90%	12/2008	91%	12/2009	93%	94%	N/A
6.2.4	Increase the mean lifespan of patients with Duchenne and Becker Muscular Dystrophy (DBMD) and carriers by 10% as measured by the Muscular Dystrophy Surveillance, Tracking and Research Network. [O]	Yes (Met)	Yes (Met)	Conduct data analysis on MD STARnet data collected in the 4 current sites and include one additional state.	Yes (Met)	Identify and report on (1) the incidence and prevalence of DBMD in the United States based on MD STARnet data (2) early signs and symptoms of DBMD based on MD STARnet and (3) cost of health care of people with DBMD.	2/2008	Report on the impact of clinic use on morbidity and mortality in DBMD using MD STARnet data	Identify and report on (1) the trends on incidence and prevalence of secondary complications related to DBMD annually based on MDSTARnet data and (2) the trends of service utilization by people with DBMD and their families based on MD STARnet data.	N/A

Long Term Objective 6.2, Performance Measure 1:

CDC employs a Universal Data Collection (UDC) system to monitor blood safety through blood sample testing of individuals seen at a network of Hemophilia Treatment Centers (HTCs) across the country. Blood samples are tested for HIV, Hepatitis A, B, and C, and other emerging infectious agents as needed. These samples provide a national repository for the testing of emerging infectious diseases to quickly identify blood-borne infections contaminating blood products used to treat bleeding disorders and prevent transmission of infectious diseases. Given that the hemophilia population utilizes more blood products than any other group, the UDC acts as an early warning network for the identification and prevention of transmission of blood borne agents. The UDC also provides information on joint mobility and function, bleeding occurrences, treatment and vaccinations.

Increasing the number of patients enrolled in the UDC is important to ensure that the majority of patients with bleeding disorders are monitored, so that complications due to the underlying bleeding disorder and other risk factors may be assessed on a population level. The enrollment measure for FY 2007 was exceeded. This exceptional enrollment may be for a number of possible reasons, including:

- A lower than anticipated refusal rate (about nine percent) compared to other national studies of this type and size;
- Increased marketing through consumer groups to promote the HTCs - patients recognize that the coordinated care approach has demonstrated decreased mortality and hospitalizations among patients visiting HTCs; and
- The extent of the HTC network, which reaches both urban and rural areas, allows catchment of patients in all areas of the country.

Long Term Objective 6.2, Performance Measure 2:

Development plays a critical role in the biological and behavioral processes that impact health and well-being throughout the lifespan, but has increased importance for immediate and long term health outcomes during infancy, early childhood, and adolescence. Healthy children are more ready to learn and are more likely to become healthy adults who will be productive members of society. Children who grow up in environments where developmental needs are not met are at an increased risk for compromised health and safety and learning and developmental delays. In addition, it has been demonstrated that adults who were exposed to four or more adverse childhood events were at higher risk for alcoholism, drug abuse, depression, suicide attempt, smoking, poor self-rated health, multiple sexual partners, STDs, physical inactivity, and obesity. In response, CDC focused on developing an innovative public health intervention to promote protective factors and ameliorate risk factors impacting developmental outcomes. This intervention is currently being tested by a multi-site randomized control trial.

In conjunction with the grantee on this project, the activity is on target with enrollment of families and data collection/analysis of the age-two cohort of children. Further analysis and possible publication of data will be considered in the upcoming fiscal year.

Long Term Objective 6.2, Performance Measure 3:

CDC's activities to support early hearing detection are important for ensuring timely referral to early intervention for all infants with hearing loss. CDC supports state-based efforts to promote and ensure that all children receive a hearing screening before one month of age. This includes infants born in hospitals as well as those born in community birthing centers, homes, and other settings. There is a two year data reporting lag.

Potential barriers and challenges for conducting hearing screening among infants up to one month of age include:

- Not all states and territories require infants to be screened. As a result not all hospitals across the country screen infants for hearing loss.
- Ensuring infants born outside of hospitals (e.g., homebirths) are screened before one month is a challenge because these infants first have to be identified and then offered hearing screening services.
- Infants in hospital NICUs may not be able to be screened before one month of age depending on their condition.
- Ensuring families of infants that were not screened before hospital discharge return for the hearing screening can be a challenge.

These above reasons also help explain why the one percent increase each year is still an ambitious target for EHDI. In addition, with the majority of infants now being screened for hearing loss greater effort is needed to ensure the remaining few percent of infants are screened. This is because in most cases the activities that can result in the majority of infants being screened have already been implemented. More specific/targeted and often more time consuming efforts are in most cases now needed to ensure all infants are screened.

At present, measures indicate that this project has exceeded the one-month hearing screening evaluation in all settings. Focus will be made to close the gap and aim for the higher measure (94 percent of all infants screened).

Long Term Objective 6.2, Performance Measure 4:

In order to achieve this goal, CDC is engaged in the development of a population-based monitoring system designed to ascertain key health information for people with Muscular Dystrophy (MD). This system, MD STARnet, is the only source of epidemiologic data necessary to engage in intervention research. Annual goals are set to document progress towards the health outcome. These benchmarks reflect essential steps in the public health process: public health surveillance, epidemiologic research, and intervention development and delivery.

HEALTH INFORMATION AND SERVICE

HEALTH STATISTICS

Health Statistics participated in the PART review in 2005. This document reflects measures adopted as a result of the PART process. While they may seem redundant, there are variations in how an outcome is being measured.

#	Efficiency Measure	FY 2004 Actual	FY 2005		FY 2006		FY 2007 Target	FY 2008 Target	FY 2009 Target	Out-Year Target
			Target	Actual	Target	Actual				
7.E.1	The number of months for release of data as measured by the time from end of data collection to data release on internet. [E,O]	13.8	13.5	2/2008	12.9	12/2008	12.4	11.9	11.4	N/A

Efficiency Measure 7.E.1:

This efficiency measure was developed through the PART process in 2005 and is serving as a long term outcome measure also. Through this measure, CDC will track improvement in the timeliness of data provided to the nation's health decision makers. In 2003, data was released in 14.5 months and serves as the baseline. The measure will address Health Statistics data in the aggregate; the unit of measurement is months. The target result for FY 2005 will now be reported in June 2008. The delay is the result of CDC not receiving the files from the states. It is expected that the data will be released in January 2008.

The mission of the Health Statistics program is to provide statistical information that will guide actions and policies to improve the health of the American people. The more timely the data are released, the faster health decision makers, policy makers, researchers, etc. will have to develop new policies or evaluate policies already implemented.

To improve timeliness of data received from the states, CDC:

- Provides on-going training on re-engineering of their systems;
- Initiated a cooperative agreement with the National Association for Public Health Statistics and Information Systems to provide individual technical assistance to states on improving their vital records operations
- Provides on-going individual feedback to states on the timeliness and quality of their data submission; discusses how they rank compared with other states, and makes recommendations for improvements
- Created a federal/state team to assist states with their systems and to develop recommendations to improve timeliness.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 7.1: Monitor trends in the nation's health through high-quality data systems and deliver timely data to the nation's health decision-makers.										
7.1.1	Percentage of key data users and policy makers, including reimbursable collaborators, that are satisfied with data quality and relevance. [O]	N/A	N/A	N/A	N/A	Establish baseline upon completion of survey(s)	12/2008	TBD	TBD	TBD
7.1.2	The number of new or revised charts and tables and methodological changes in *Health, United States*, as a proxy for continuous improvement and innovation in the scope and detail of information.	21	36	15	5 new detailed trend tables and 19 new charts (Met)	15	5 new detailed trend tables and 21 new charts (Met)	15	15	N/A
7.1.3	Number of improved user tools and technologies and web visits as a proxy for the use of NCHS data.	7/3.775M	5/5.608M	5/6.450M	5/6.7M (Met)	5/6.8M	5/6.9M (Met)	5/7.1M	5/7.466M	N/A

Long Term Objective 7.1, Performance Measure 1:

This measure addresses the performance element of quality and relevance. CDC will implement a systematic approach and tool for assessing the satisfaction of key data users and policy makers (e.g., reimbursable collaborators, Assistant Secretary for Planning and Evaluation, OMB, Congressional Research Service, and others) relative to data quality and scope. The Health Statistics Board of Scientific Counselors will help identify the list of key data users and policy makers to be surveyed, along with those organizations that directly work with CDC through interagency agreements. Performance results will be used by CDC managers to drive program improvements.

Three of the four survey categories have been completed. Implementation of the final survey category for web users is currently on hold due to staffing issues. In addition, the current CDC E-gov priorities have focused on improving the CDC website and implementing recommended improvements, which will have an impact on the Health Statistics program's website. Results of all four surveys are now expected to be reported in December 2008.

The survey results to date are as follows: Reimbursable customers, 91 percent Good or Excellent; Data User Conference members, 91 percent Good or Excellent. Power Users and Data User Conference focus group members' results were qualitative and generally positive with suggestions for improvement. The program is currently implementing communication suggestions for conducting briefings and forums to seek input into surveys.

The Data User Conference Group and focus group members will be surveyed again in FY 2008, with results available by September 30, 2008. The goal will be to attain a five percent increase in the Excellent Category results (38.4 percent Excellent, 53.4 percent Good). Additional Power Users will be surveyed again in 2008 with results reported by September 30, 2008.

By providing quality data, CDC provides the tools necessary for decision makers to plan, implement, and evaluate interventions to improve health.

Long Term Objective 7.1, Performance Measure 2:

This measure addresses the performance element of scope. *Health, United States*, the most comprehensive publication produced by CDC, draws information from each data system, as well as data from other federal partners and collaborators. Improvements in the scope and detail of *Health, United States* are a proxy for the scope of data produced and made available by CDC. Improvement and innovation in *Health, United State*s can be assessed through four components: 1) new charts in the Chartbook; 2) new trend tables; 3) tables substantially revised; and 4) major methodological changes. Published archived volumes can be inspected yearly and compared to their predecessors to measure the continuous improvement and innovation. The target for FY 2007 has been met with the release of five new trend tables and 21 new charts.

Health, United States, 2007 includes five new trend tables on:

- Estimates of the prevalence of selected health conditions (Table 69), based on data from the National Health and Nutrition Examination Survey;
- Reduced access to medical care due to cost in selected states (Table 80), based on data from the National Health Interview Survey;
- International comparisons of magnetic resonance imaging (MRI) and computed tomography (CT) scanners (Table 119), based on data from the Organization for Economic Co-operation and Development and the CT and MRI Census; and
- Mental health and substance abuse treatment expenditures (Tables 126 and 127), based on data from the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services and Center for Substance Abuse Treatment and the Centers for Medicare & Medicaid Services.

The *Health, United States, 2007* Chartbook section includes new charts on the foreign-born population (Figure 2), expenditures for mental health services and substance abuse treatment (Figures 7 and 8), blood cotinine levels among children (Figure 10), emergency department visits among adolescents for alcohol-related reasons (Figure 11), and restaurant meal consumption (Figure 12). The Special Feature includes 16 charts on access to care (Figures 21-36).

In addition, the book incorporated major changes in all natality tables to account for the ongoing implementation of the new birth certificate data that is the basis for most of the trend tables on natality. These changes, as well as modifications to selected mortality tables (notably the tables on race and ethnicity that include infant mortality data) will be ongoing over the next several years until all states have adopted the new birth and death certificates.

Health, United States is the HHS Secretary's annual report to Congress on the health status of the nation and the Health Statistics program's most comprehensive publication. The data collected are the baselines to which many other national, state, and local survey results are compared. The publication assesses the nation's health by presenting trends and current information on selected determinants and measures of health and health care utilization, resources and expenditures. These data are utilized widely by researchers, policy makers, and Congressional staff, so by adding the new charts and tables and improving methods, they have new data to use for policy making and evaluation of public health programs.

The target of 15 new or revised charts and tables and methodological changes in *Health, United States* has been exceeded the past two years due to major resources being devoted to the Special Feature, which is the source of the majority of new charts included in the publication. However, it is difficult to predict competing priorities, methodological modifications that need to be incorporated in any given year, or new data sources that can be tapped to produce new trend tables. During FY 2008, several competing tasks will now be addressed by the group producing *Health, United States*,

including strategic planning for the Coordinating Center for Health Information and Service (CCHIS) and publication of data briefs, so it is very possible that fewer new charts will be included in the 2008 edition. In addition, trend tables are much more resource-intensive to produce than are charts, and in future years it is possible that the Health Statistics program will include more new trend tables and fewer charts. Therefore the target of 15 new charts, trend tables, or major modifications will continue to be ambitious.

Long Term Objective 7.1, Performance Measure 3:

A primary objective of CDC is to maximize the use of data collected through investment of public funds. As the use of data increases, so does the return on investment. One way to increase use is to make data available in more easily accessible forms. CDC makes its data available in a variety of forms through the internet and works to improve the speed and efficiency with which people access the data by: 1) development of data input statements/programs that allow people quick access to data files; 2) development of masked variance files that allow researchers to more quickly access data; 3) development of Fast Stats and Quick Stats to quickly access data files; and 4) use of Beyond 20/20 software making it more likely that systems such as the CDC Data Warehouse on Trends in Health and Aging, Health Data for All Ages, Data Resource Center for Child and Adolescent Health, and Healthy People 2010, will be found and used, thereby increasing the use of data already collected. The FY 2007 target of five new improvements and 6.8 million visits to the website has been met.

The goal of five new improvements per year is considered ambitious as the development of new technologies and improvements to existing tools requires an enormous amount of resources to not only create the modules, but also to test them.

During FY 2007, the following improvements have been made on the CDC website:

- Division of Vital Statistics now provides birth and perinatal mortality public use data files that allow data users to do basic and sophisticated data analyses. These were previously only available through CD-ROM and main frame computer.
- National Health and Nutrition Examination Survey (NHANES) has developed the second web-based online tutorial (NHANES III) to help users navigate, use, and analyze NHANES data files. This tutorial supplements the Continuous NHANES tutorial.
- National Health Interview Survey historical file was released with microdata files for 1969, previously only available via magnetic tape and CD-ROM.
- Summary Measures of Health website provides an ongoing mechanism for sharing information about activities and progress in the field of summary measures for improving the measurement of health and tracking the burden of disease.
- Three new public-use versions of linked mortality files have been released: 1986-2000 National Health Interview Survey, Longitudinal Study of Aging, and the Third National Health and Nutrition Examination Survey. CDC Data Linkage activities also include linkages of Health Statistic's surveys to Medicare enrollment and claims data as well as Social Security disability information.

CDC expects the number of web visits to increase through continued promotion of the website at conferences, through newsletters and other publications. As new tools and technologies are developed, this in turn will generate new interest in the data. In addition, plans are being developed for the launch of a new NCHS.gov page which will increase user visits and make the navigation easier for new users. The new page will be promoted at the Health Statistics Data Users Conference in August 2008 using the new templates and design guidelines from CDC.

HEALTH MARKETING

#	Efficiency Measure	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
9.E.1	Provide "just-in-time" scientific information and education via multiple communication channels to thousands of health professionals, thereby reducing the cost and time of distributing the latest science based information. [E]	N/A	92,790 (9% increase) (Exceeded)	5% increase from previous year in number of participants registered in distance learning activities.	99,409 (7% increase) (Exceeded)	5% increase from previous year in number of participants registered in distance learning activities.	82,919	5% increase from previous year in number of subscribers and participants of CDC's professional communications projects and distance learning activities.	5% increase from previous year in number of subscribers and participants of CDC's professional communications projects and distance learning activities.	N/A

Efficiency Measure 9.E.1:

The most important tool for frontline practitioners is current, "just-in-time" information and knowledge. Public health and healthcare information must be continuously updated, translated, and communicated to meet changing conditions and threats. Further, information must be available in the form most useful and accessible to health professionals. To meet these needs, CDC maintains systems for information and knowledge transfer, and ensuring that scientific and medical information is translated and communicated effectively, and that best practices of public health professionals are shared nationwide. Due to the creation of the National Center for Health Marketing in 2004, this measure has been revised to reflect multiple communication channels that are aligned beyond distance learning alone. The baseline year is 2003 and saw 84,112 participants registered in distance learning activities.

Because the channels vary in their maturity and purpose, CDC anticipates refinement of this measure to reflect the differences between the various communication channels. For example, an increase in participants/membership is an excellent measure for some channels, while improved response time to test messages is a more reflective measure for others. In addition to decreasing response time, increasing the numbers of health professionals who subscribe to CDC channels, and increasing participants in distance learning opportunities, CDC is dedicated to ensuring that the organizations representing the most relevant and impacted health professionals can be reached by CDC channels with actionable information. Although difficult to measure, efforts will be made to identify and enroll those organizations with the widest and deepest reach to health professionals in FY 2008 and FY 2009.

CDC's activities provide leadership in the development of principles, strategies, and practices for effective communication to the public and other key CDC audiences for health promotion and disease prevention. They also function as a CDC-wide forum for development and adoption of emergency health communication policies and procedures. Additionally, they increase access to science-based health messages to increase impacts on the health of our customers. As a result projected targets for FY 2005, FY 2006, and FY 2007 have been met and it is anticipated that the targets for the subsequent years will be met as well.

The performance target for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 9.1: CDC will maintain and improve its website and electronic communications to provide science-based health information to health care professionals, CDC partners and the American public.										
9.1.1	Increase access and utilization of CDC.gov by public, partners, and other health care professionals.	N/A	N/A	N/A	N/A	Establish Baseline	450 million	Baseline + 5%	Baseline +10%	N/A

Long Term Objective 9.1, Performance Measure 1:

CDC's website, http://www.cdc.gov, is the primary information source for CDC's various audiences. To ensure rapid dissemination of CDC's scientific information and to ensure broad adoption and application of that scientific research into practice, CDC's scientific information must be distributed in formats (i.e., audio, video), versions (i.e., health professionals/patient) and languages used by its constituents. In addition, CDC's website must increasingly promote its content to various audiences to expedite awareness and usage of the most current scientific information available.

In FY 2007, large-scale usability testing (including in-lab tests; internal surveys; external surveys; and a comprehensive review of data from the past two years of the American Customer Satisfaction Index reporting) was conducted on the CDC.gov website. The usability testing data was used to create an improved site where users will be able to find the information they are looking for in a faster and more efficient manner.

To establish the FY 2007 baseline, CDC implemented new techniques for maintaining the web site and its more than 250,000 pages, which included: creating a cross-cutting web governance structure to build an organized yet collaborative system for improving CDC's web site; creating a content inventory tool to track web content owners and review dates for data; implementing a system where users can be notified when web pages are updated; and outlining a three-year plan for the adoption of a content management system.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 9.2: Increase the number of frontline public health workers at the state and local level that are competent and prepared to respond to bioterrorism, infectious disease outbreaks, and other public health threats and emergencies; and prepare frontline state and local health departments and laboratories to respond to current and emerging public health threats.										
9.2.1	Increase the usage of CDC's online public health emergency alert systems, training materials, and other electronic resources/tools designed to provide information, educational materials, and real-time alerts as measured by the number of subscribers to Epi-X, HAN and national public health radio networks.	N/A	N/A	Baseline	4,372 users	Increase by 5% above baseline	4,885 users (met)	Increase by 15% above baseline	Increase by 20% above baseline	N/A

Long Term Objective 9.2, Performance Measure 1:

Improving the usage of CDC's online public health emergency alert systems, training materials, and other electronic resources/tools will have immediate and lasting impact on CDC's ability to protect citizens from natural hazards and terrorism threats. For example, CDC's Epi-X emergency alert system for public health officials nationwide could be expanded to alert other key sectors including government officials, medical officers for businesses, and health care leaders about health emergencies. CDC's online learning tools to train first responders and public health officials involved in preparing for and responding to national emergencies improves CDC's to protect the U.S. This will be particularly critical in preparing for a pandemic that may isolate individuals from social gatherings, work, medical facilities, etc.

In FY 2007, efforts were made to ensure that the appropriate individuals were subscribed to the various channels. In doing so, it was realized that the projected increase (target) was not appropriate given the metrics associated with each channel.

The original intent of the measure (as stated above) was to combine the reported outputs for each of the various channels. However after careful review, it was determined that a nonspecified increase in participants/membership was an inappropriate measure for each of the given channels (Epi-X, HAN, etc.). Because the channels vary in their maturity and purpose, CDC anticipates refinement of this performance measure to reflect the differences between the various communication channels. Performance measures for future years (FY 2008 and FY 2009) will be separated out to more accurately capture individual measures and targets for each channel.

For example, the Epi-X system is a secure network restricted to only those with a need to know in local/state public health departments. Ensuring that the right officials can access, open/review reports, and post relevant reports is a more appropriate measure for this channel. Currently, 29/58 states, territories and select cities have at least 80 percent of their key roles subscribing to Epi-X. The projected FY 2008 measure will target a ten percent increase in the number states, territories and select cities that have active Epi-X users representing at least 80 percent of their key public health roles.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 9.3: CDC will maintain and improve its multi-media broadcast capabilities (e.g. satellite television, webcasts, podcasts, video) to provide science based health information to health care professionals, CDC partners and the American public.										
9.3.1	Increase the number of multi-media broadcast outputs to partners and health professionals.	N/A	N/A	N/A	N/A	Establish Baseline	40	Baseline + 5%	Baseline + 10%	N/A

Long Term Objective 9.3, Performance Measure 1:

The scientific information produced by CDC is only as effective as its translation for and delivery to the many health care, partner and public audiences with which the agency interacts. Satellite distance learning broadcasts for health care professionals have been produced by CDC for many years. In addition, television can be used more broadly with broadcasts to reach the public as well as partners. With the proliferation of new technologies that allow delivery of information to very specific audiences, CDC can now access and use a broad array of multi-media channels to quickly translate science into usable information accessible in many formats (e.g., public cable television, web casts, voice pod casts, etc).

FY 2007 baseline data has been established for this measure at 40. It is anticipated that this baseline figure will increase by five percent in FY 2008.

In FY 2007, CDC subject matter experts and professionals worked to produce more than 200 audio and video podcasts which as of September 2007 had been downloaded more than 275,000 times serving to educate, inform and engage the general public regarding vital public health issues. The CDC.gov web site provided download access and tracking of CDC podcasts developed in collaboration with others across CDC. As of September 9, 2007, users downloaded or viewed about 450,000 CDC podcasts, with an average of 1,000-1,500 download per day. CDC podcasts can be downloaded from CDC.gov and from iTunes.

To establish the FY 2007 baseline, CDC employed innovative and rigorous strategies for reaching its customers based on audience and communication research, and provided its customers access to effective, real-time health and safety information, interventions, and programs through communications channels they prefer. These efforts will continue in FY 2008 to achieve the projected target.

These efforts assure CDC content, disseminated through various channels to the public and other targeted audiences is coordinated throughout the agency and is accurate, consistent, accessible, actionable, and evaluated for usability and customer satisfaction.

ENVIRONMENTAL HEALTH AND INJURY PREVENTION

ENVIRONMENTAL HEALTH

#	Efficiency Measure	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Efficiency Long Term Objective: Promote effective and efficient NCEH management.										
10.E.1	Number of Full Time Equivalent (FTE)'s providing program support through the Office of the Director per $1 million in total program budget. [E]	N/A	0.67	0.66	0.55 (Exceeded)	0.65	0.66 (Unmet)	0.64	0.64	N/A

Efficiency Measure 10.E.1:

This measure was established to capture administrative efficiencies resulting from reducing the size of the CDC NCEH/ATSDR Office of the Director by decreasing the number of the office's program-support FTEs per million dollars. It is anticipated the efficiencies gained in this measure will continue to remain relatively constant in the future.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 10.1: Determine human health effects associated with environmental exposures.										
10.1.1	Number of environmental chemicals, including nutritional indicators that are assessed for exposure of the U.S. population.	150 (Met)	230 (Exceed-ed)	180	274 (Exceed-ed)	250	293 (Exceed-ed)	280	323	N/A
10.1.2	Complete studies to determine the harmful health effects from environmental hazards.[1]	27 (Exceed-ed)	44 (Exceed-ed)	25	34 (Exceed-ed)	25	36 (Exceed-ed)	12	25	N/A
10.1.3	Number of laboratory quality standards maintained in certified or participating laboratories for tests such as lipids; newborn screening; those predictive of type 1 diabetes; blood lead, cadmium, and mercury; and nutritional factors.	866	904 (Unmet)	990	987 (Unmet)	1,001	1,001 (Met)	967	959	N/A

[1] Targets have been restored for FY 2009 to reflect reinstatement of funding levels for programs that contribute to this measure.

Long Term Objective 10.1, Performance Measure 1:

This measure reflects the efforts of CDC's Environmental Health Laboratory's biomonitoring program. In 2005, the Environmental Health Laboratory published the most recent version of the *National Report on Human Exposure to Environmental Chemicals,* an ongoing assessment of the U.S. population's exposure to environmental chemicals. These data provide unique exposure information to scientists, physicians, and health officials to help prevent disease that results from exposure to environmental chemicals. Since 2004, CDC has added 143 chemicals to the number of chemicals (including nutritional indicators) for which it assesses exposure levels in the U.S. population, bringing the total number up to 293, thereby exceeding the FY 2007 target of 250. The FY 2007 target, established during Environmental Health's 2005 PART review, was ambitious given past trend data and existing laboratory methodologies. The budget

year target for this measure was increased given past performance of significantly exceeding FY 2005 through FY 2007 targets. This achievement is due to scientific advancements, such as increasing the number of chemicals that can be measured in a single sample and developing sophisticated new methods for analyzing chemicals that will increase the laboratory's exposure-assessment capabilities. As the nation's premier public health laboratory, CDC's Environmental Health Laboratory continually pursues methods to advance the efficiency and impact of its scientific efforts. In FY 2007, the Environmental Health Laboratory added an additional process to its reporting of biomonitoring results as a means of releasing information to the public as soon as possible. This process involves publishing results for priority chemicals in the peer-reviewed literature once data analysis is complete and then later publishing summary information about these chemicals in the Report. Expanding the knowledge base and improved timeliness in providing results will assist public health practitioners in effecting interventions to prevent or ameliorate diseases from environmental exposures.

Long Term Objective 10.1, Performance Measure 2:

This measure reflects the efforts of CDC's Environmental Hazards and Health Effects (EHHE) Program. CDC investigates the human health effects of hazards in the environment, such as water and air pollutants, mold, and radiation as well as hazards related to natural and other disasters. The results of these investigations and studies help CDC develop, implement, and evaluate actions and strategies for preventing or reducing harmful exposures and their health consequences. The FY 2004 and FY 2005 targets were based on CDC efforts to determine the human health effects associated with environmental exposures by conducting or collaborating on a variety of scientific studies and available funding for such studies. In FY 2006 and FY 2007, the targets increased based on the actual numbers for FY 2004 and FY 2005 (these studies were related to responses to specific state requests—a number of which were related to extreme weather emergencies), and was reduced for FY 2008 due to elimination of funding for an EHHE program that contributed significantly to this measure. In FY 2009, the target has been restored to 25 in light of reinstatement of funding levels for programs that contribute to this measure.

Long Term Objective 10.1, Performance Measure 3:

This measure ensures the quality of several different tests in a large number of laboratories that voluntarily participate in quality assurance and standardization programs. Although CDC makes every effort to encourage participation in these programs, it cannot compel laboratories to participate. The targets realistically reflect the fact that participation in these voluntary standardization programs fluctuates from year to year, depending on multiple factors, including CDC laboratory requirements and import restrictions of other nations. Future targets are the program staff's best estimates; however, because of the voluntary nature of the program and other conditions beyond the control of the program (i.e., import restrictions), there is no way to predict with any certainty the number of laboratories that will participate in the future.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 10.2: Prevent or reduce illnesses, injury, and death related to environmental risk factors.										
10.2.1	Percentage reduction in asthma hospitalizations in states funded for partial and full implementation per 100,000 people. [O]	N/A	12/2008	Part A Enhanced: 6% Part B: 12%	12/2009	Part A Enhanced: 7% Part B: 14%	12/2010	Part A Enhanced: 8% Part B: 15%	Part A Enhanced: 9% Part B: 16%	N/A
10.2.2	Number of children under age 6 with elevated blood lead levels. [O] [1]	240,000 (Baseline)	6/2008	190,829	12/2008	169,399	12/2009	135,588	107,363	N/A
10.2.3	Percentage increase in the capacity of state health departments to anticipate and prevent the spread of illness/disease outbreaks from food– and water-borne illness.	16% (Baseline)	86% (Exceeded)	35%	90% (Exceeded)	50%	100% (Exceeded)	90%	100%	N/A

[1]Baseline and targets have been adjusted to reflect the latest data available from the 2004 NHANES report.

Long Term Objective 10.2, Performance Measure 1:

This measure reflects CDC's efforts to reduce asthma-related morbidity in affected populations in funded states.

CDC aims to reduce hospitalizations due to asthma by helping state coalitions create and implement comprehensive asthma control plans that include science-based interventions, partnerships, and asthma tracking systems. Asthma surveillance data is used to identify and provide interventions to people most in need, thereby preventing hospitalizations and other adverse health effects of asthma. This effort is measured by direct target goals set by Healthy People 2010 and is driven by HHS's strategic goal to "prevent and control disease, injury, illness, and disability across the lifespan, and protect the public from infectious, occupational, environmental, and terrorist threats."

CDC funded 34 state/city/territory grantees in FY 2007 to develop or implement comprehensive asthma control plans. Part B grantees (Michigan, New York, Oregon, California, Illinois, and Minnesota) are funded to fully implement their asthma control plans. This measure is based on the HP 2010 goal of reducing hospitalizations for asthma (goal 24.2). Part A-enhanced (partial implementation) and Part B states represent 59 percent of the U.S. population.

The reporting dates for this measure have been revised to more correctly reflect the data lag. Issues regarding the quantity, quality, and non-standardized collection of asthma data in states will affect the program's ability to report on this measure. Currently, CDC obtained partial data for FY 2003. For five of the six Part B states, the age-adjusted hospitalization rate for FY 2003 is 148. The baseline for Part B states is 146.95; therefore, the partial results for FY 2003 are not significantly different enough from the actual to make a determination about whether hospitalizations are trending up, down, or are level. However because of a number of challenges associated with collecting a consistent set of hospital data from funded states, the program plans to develop a new measure to better reflect direct program activities.

Long Term Objective 10.2, Performance Measure 2:

Authorized in 1998, the CDC Childhood Lead Poisoning Prevention Program uses funding received to develop programs and policies to prevent childhood lead poisoning; educate the public and health-care providers about childhood lead poisoning; fund state and local health departments to determine the extent of childhood lead poisoning by screening children for elevated blood lead levels; help to ensure that lead-poisoned infants and children receive medical and environmental follow-up; and develop neighborhood-based efforts to prevent childhood lead poisoning.

In FY 2007, the program modified its targets to reflect an upward revision in the estimated number of children with elevated BLLs based on the most recently available NHANES data. While the program is on track to meet its long term goal of eliminating childhood lead poisoning as a public health issue, this may not be accomplished by 2010, the current target date. Factors that contribute to moving the target out-year include the upward revision in the number of young children with elevated blood lead levels, the extent to which needed resources are available, the inherent difficulties in reaching those most in need of screening, and the continued influx of children with high lead levels from other countries. The program's strategy for making progress toward meeting the target includes continuing to focus on a range of primary prevention activities to prevent exposures, provide training to local and state public health agencies, and work with strategic partners to leverage resources. In addition, CDC continues to maintain capacity for responding to acute mass exposures such as lead in toys, traditional medicines, and pottery.

As of the end of 2007, the NHANES data relating to the estimated number of children with elevated blood lead levels for 2005 and 2006 was being processed. (The data is processed in two year batches in order to increase the statistical accuracy of the estimates.) The data should be available by June 2008.

Long Term Objective 10.2, Performance Measure 3:

This measure tracks the increased capability of states to prevent and respond to outbreaks from food, water, and air contaminants/vectors. CDC currently works with 427 state and local environmental health service (EHS) delivery programs to increase their capacity to prevent the spread of outbreaks from food- and water-borne illness. As a result of CDC efforts, 100 percent of state health departments have increased their capacity due to CDC products and services. Some of the products and services provided by CDC include: 1) training state health department employees in environmental health leadership, management, and emergency response; 2) creating and implementation the Environmental Health Specialist Network (EHS-Net) that helps to prevent illnesses due to food and water contamination; 3) distributing information and guidance products to states (e.g., relating to healthy homes, integrated pest management (to prevent vector-borne illnesses), swimming pool inspections, etc); 4) creating and implementing the Protocol for Assessing Community Excellence in Environmental Health (PACE-EH) tool used by state and local communities to identify and prioritize environmental health issues; and 5) providing technical assistance to various states. These along with other CDC efforts have contributed to increased capacity among state environmental public health programs.

INJURY PREVENTION AND CONTROL

#	Efficiency Measure	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
11.E.1	Reduce the amount of time to submit funding packages for non-research funding opportunities to CDC's Procurement and Grants Office. [E]	N/A	N/A	Establish baseline.	52 days (Met)	26 days	21 Days (Exceeded)	13 days	7 days	N/A

Efficiency Measure 11.E.1:

In February, 2006 CDC's Procurement and Grants Office (PGO) established four agency-wide key performance indicators (KPIs) and targets that outline the amount of time required to award a new grant or cooperative agreement. The KPIs are based on current PGO cycle times. The funding package cycle time defined as the time from the conclusion of the review panel until the funding package is sent to PGO.

During this time frame, the Injury Prevention and Control program is required to summarize the reviews (primary and secondary) of each application for a particular funding opportunity and develop a funding package document to submit to PGO. PGO's requirement for this time frame is seven days. The program's Efficiency Measure tracks the efforts to meet this overarching KPI. In FY 2006, the Injury Control and Prevention program took an average of 52 days to submit the funding package to PGO. In FY 2007, the program exceeded its target of 26 days by submitting its funding package document to PGO in 21 days, a reduction of 31 days in one year. The Extramural Tracking System (NEXT) is used to verify performance for this measure.

INTENTIONAL INJURY

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 11.1: Achieve reductions in the burden of injuries, disability, or death from intentional injuries for people at all life stages.										
11.1.1	Reduce youth homicide rate by 0.1 per 100,000 annually. [O]	8.9/ 100,000	9.2/ 100,000 (Unmet)	N/A	N/A	N/A	N/A	8.8/ 100,000	8.8/ 100,000	8.7/ 100,000 (FY 2010)
11.1.2	Reduce victimization of youth enrolled in grades 9-12 as measured by a reduction in the lifetime prevalence of unwanted sexual intercourse, the 12-month incidence of dating violence, and the 12-month incidence of physical fighting. [O]	N/A	A) 7.5% (Unmet) B) 9.2% (Unmet) C) 35.9% (Unmet)	N/A	N/A	A) 6.9% B) 8.4% C) 30.3%	12/2008	N/A	A) 6.7% B) 8.1% C) 29.3%	A) 6.4% B) 7.7% C) 28.4% (FY 2011)

Neither of these measures was met for FY 2005 or FY 2006. There are many factors that contribute to youth violence and youth victimization rates, including economic conditions, lifestyle behaviors, and social and physical environments. CDC works to prevent this violence by identifying effective strategies that reduce risk factors and increase promotive and protective factors at the individual, family, and community levels. As trends in these risk factors change, such as poorer economic conditions or changes in the prevalence and types of substance abuse, youth violence and youth victimization may increase. CDC will continue to evaluate and

modify efforts to achieve its targets in reducing incidences of youth homicide and unwanted sexual intercourse, dating violence, and physical fighting.

Long Term Objective 11.1, Performance Measure 1:

This measure is monitored utilizing data from persons aged 10-24 years among states participating in the National Violent Death Reporting System (NVDRS) in 2003. This measure contributes to CDC's long term PART goal to reduce homicide rates among youth aged 10-24 by 10 percent in NVDRS states with FY 2003 baseline data.

Youth homicide is the second leading cause of death for youth ages 10-24 years in the U.S. and the fourth leading cause of death for children ages 1-14 years.

The age span of the target population for this measure is being changed from 15-24 years of age to 10-24 years of age to correspond with the same age category contained in NVDRS, the data source. The revised age group conforms to the NVDRS 2003 baseline data.

Long Term Objective 11.1, Performance Measure 2:

This measure contributes to CDC's long term PART goal to impact self-reported victimization of youth as measured by reductions in two of three of the following: unwanted sexual intercourse, dating violence, and physical fighting.

CDC funds numerous programs and activities to address the victimization of youth. The data source of youth victimization is CDC's Youth Risk Behavior Survey (YRBS). In the YRBS, students enrolled in grades nine to twelve are asked these questions:

- During the past 12 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?
- Have you ever been physically forced to have sexual intercourse when you did not want to?
- During the past 12 months, how many times were you in a physical fight?

UNINTENTIONAL INJURY

#	Key Outcomes	FY 2004 Actual	FY 2005		FY 2006		FY 2007 Target	FY 2008 Target	FY 2009 Target	Out-Year Target
			Target	Actual	Target	Actual				
Long Term Objective 11.2: Achieve reductions in the burden of injuries, disability or death from unintentional injuries for people at all life stages.										
11.2.1	Among the states receiving funding from CDC, reduce deaths from residential fires by 0.01 per 100,000 population. [O]	N/A	N/A	N/A	N/A	N/A	1.13/ 100,000	1.12/ 100,000	1.11/ 100,000	N/A
11.2.2	Achieve an age-adjusted fall fatality rate among persons age 65+ of no more than 69.6 per 100,000. [O]	39.2/ 100,000 (Unmet)	41.2 /100,000	4/2008	43.4/ 100,000	10/2008	45.6/ 100,000	47.8/ 100,000	50.0/ 100,000	N/A
11.2.3	Decrease the estimated percent increase of age-adjusted fall fatality rates among persons age 65+ years. [O]	5.52% (Unmet)	8.39% reduction	4/2008	8.82% reduction	10/2008	9.10% reduction	9.30% reduction	9.45% reduction	N/A

Long Term Objective 11.2, Performance Measure 1:

This measure contributes to CDC's long term PART goal to reduce deaths from residential fires to 1.02 per 100,000 population among states receiving funding from CDC. This measure contributes to CDC's long term strategy to reduce deaths from residential fires to 1.02 per 100,000 population among states receiving funding from CDC. CDC anticipates that the target for 2007 will be met, as the field continues to make strides in residential fire safety and prevention. Policy decisions are being made at state and local levels that contribute to fewer deaths from residential fires, such as requirements for the sale of fire-safe cigarettes. While the field continues to see improvements in deaths from residential fires, achieving success is depending upon a number of factors such as developing new countermeasures and technologies to lower risks for fires; conducting research and surveillance to understand emerging issues as they arise and become a factor in deaths from residential fires; and, conducting research on effective prevention strategies that can be implemented in the home. As new data will not be available until 2009, the existing targets will remain as is until more information can be gathered about trends in this area.

Long Term Objective 11.2, Performance Measures 2 and 3:

This measure was not met for FY 2004, the first year of implementation of a process to track the new older adult falls baseline measures. The target of 39.0 per 100,000 population was based on a best estimation of an achievable result, given trends and existing prevention efforts. The reasons CDC is not meeting the targets on falls are unclear, but rates of older adult fall deaths are increasing. Several factors that may be contributing to this increase are that the average life expectancy has increased and death rates from cardiovascular and chronic diseases have decreased. In addition, although the fatality rates were adjusted for age, additional age-related factors may explain the increasing rate. Advancing age is associated with physiologic changes, including decreased muscle strength and endurance, delayed reaction times, slowed reflexes, and loss of visual acuity. These changes may interact with use of psychoactive medications and chronic conditions, such as osteoporosis, arthritis, and diabetes, which put older adults at high risk of sustaining fatal fall injuries. The data for this measure has been delayed due to circumstances outside of the center's control. Data are expected soon but the precise time frame is not known.

Efforts are underway to decrease deaths from falls among older adults. For example, within HHS, CDC is collaborating with states to provide custom exercise classes designed to improve strength, balance, and mobility; education about how to reduce fall risk factors; assistance to improve the home environment; and medical referrals as appropriate. CDC will seek to revise its measures to reflect milestones and outcomes which may be more practical to achieve given resources, capacity, and trends in this important cause of morbidity and mortality in the U.S.

OCCUPATIONAL SAFETY AND HEALTH

#	Efficiency Measure	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
12.E.1	Percent of grant award/funding decisions made available to applicants within nine months of application receipt or deadline date, while maintaining a credible and efficient, two-level peer review system. [E]	N/A	60%	66%	68% (Exceeded)	69%	70% (Exceeded)	72%	75%	N/A

Efficiency Measure 12.E.1:

CDC partners with the National Institutes of Health (NIH) Center for Scientific Review to process grant applications. In keeping with the effort to coordinate resources across HHS, CDC utilizes NIH's peer review and management system computer program (IMPAC II) for receipt and referral of grant applications. By doing so, CDC streamlines services for the extramural community, ensures uniformity of responses to applicants, and achieves cost efficiencies for CDC. The two-pronged approach to peer review is highly praised in the scientific community and is considered the gold standard for quality peer review. IMPAC II is a real-time system that can be monitored at any stage of the approval process. This review system is based on an eight to nine month timeline. Recognizing the valuable contributions of extramural scientists and educators, CDC works diligently to process grant applications in a timely manner. These efforts have enabled the agency to improve efficiency and exceed performance targets from FY 2006 to present, increasing from the FY 2005 baseline of 60 percent. This measure was developed through the 2004 PART process.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 12.1: Conduct research to reduce work-related illnesses and injuries.										
12.1.1	Progress in targeting new research to areas of occupational safety and health (OSH) most relevant to future improvements in workplace protection.	N/A	N/A	Evaluate relevance of second 1/5 of CDC NIOSH program activities according to specifications below	Met	Evaluate relevance of third 1/5 of CDC NIOSH program activities according to specifications below.	12/2008	Evaluate relevance of fourth 1/5 of CDC NIOSH program activities according to specifications below.	Evaluate relevance of final 1/5 of CDC NIOSH program activities according to specifications below.	N/A
12.1.2	Improve the quality and usefulness of tracking information for safety and health professionals and researchers	A) 153 research and intervention projects were based on tracking information;	A) 150 research and intervention projects were based on tracking information; B) 11 intervention	A) Evaluate the role that tracking information had in designing research and intervention projects.	A) 155 research and intervention projects were based on tracking informatio	A) Evaluate the role that tracking information had in designing research and	A) 211 research and intervention projects were based on tracking	A) Evaluate the role that tracking information had in designing research and intervention projects. B) Identify	A) Evaluate the role that tracking information had in designing research and	N/A

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
	in targeting research and intervention priorities; measure the success of implemented intervention strategies.	B) 21 intervention programs used tracking information to demonstrate the success of the intervention strategy; C) 3% reduction in the prevalence rate of elevated blood lead levels in adults, 16 and older (9.3 adults per 100,000) (All Met)	programs used tracking information to demonstrate the success of the intervention strategy; C) 8.0 adults per 100,000 with elevated blood lead levels (All Met)	B) Identify the role that follow-up tracking information can have in assessing the success of interventions. C) Heighten use of tracking data as a way to reduce the prevalence rate of elevated blood lead concentrations in persons due to work exposures by 3%.	n (Met); B) 15 interventi on programs used tracking informatio n to demonstr ate the success of the interventi on strategy (Met); C) 7.6 adults per 100,000 with elevated blood lead levels (All met)	interventi on projects. B) Identify the role that follow-up tracking informatio n can have in assessing the success of interventi ons. C) Heighten use of tracking data as a way to reduce the prevalenc e rate of elevated blood lead concentra tions in persons due to work exposure s by 3%.	informat ion (Met); B) 34 interven tion projects used tracking informat ion to demons trate the success of the interven tion strategy (Met) C) 6/2008	the role that follow-up tracking information can have in assessing the success of interventions. C) Heighten use of tracking data as a way to reduce the prevalence rate of elevated blood lead concentration s in persons due to work exposures by 3%.	interventio n projects. B) Identify the role that follow-up tracking informatio n can have in assessing the success of interventio ns. C) Heighten use of tracking data as a way to reduce the prevalenc e rate of elevated blood lead concentrat ions in persons due to work exposures by 3%.	
12.1.3	Percentage of NIOSH programs that will have completed program-specific outcome measures and targets in conjunction with stakeholders and customers.	N/A	36% (Exceeded)	50%	52% (Exceeded)	60%	61% (Exceeded)	70%	80%	N/A

Long Term Objective 12.1, Performance Measure 1:

CDC entered into a contract with the National Academies (NA) to conduct a comprehensive review of its occupational safety and health research program portfolio. In FY 2005, the NA Framework Committee established comprehensive evaluation criteria and assembled evaluation committees for the first phase of the review – mining and hearing loss prevention. The development of quantitative evaluation criteria was an extensive process, and took longer than expected. Once completed, the NA evaluation committees used the evaluation criteria to conduct the reviews of CDC's occupational safety and health research programs. To provide the NA committees with ample time to conduct the reviews, the reporting deadlines were extended. As of December 2007, NA panels have reported favorably on the hearing loss, mining and agriculture research programs. In FY 2008, NA evaluation panels will complete evaluations and report on a number of research programs in the portfolio, including: respiratory diseases, traumatic injury, construction, personal protective equipment, and health hazard evaluation. The results of these reviews will provide NIOSH with insight for the future direction of OSH research. CDC will utilize the results and recommendations from the evaluations to determine the future direction of Occupational Safety and Health (OSH) research and greatly improve the safety and health of workers

Long Term Objective 12.1, Performance Measure 2:

CDC supports several state-based surveillance activities and maintains national databases of occupational injuries and fatalities. Linked to this health information is the identification of exposures to hazards that can lead to illness and injury. With this information, specific research initiatives can be undertaken to understand the relationships between exposures and health outcomes. In turn, intervention strategies are developed and implemented to reduce illness and injury.

CDC continues to meet its performance targets by using surveillance information to develop and evaluate projects. In FY 2007, 211 research and intervention projects were based on tracking information, and 34 intervention programs used tracking information to demonstrate the effectiveness of the programs' strategies. From FY 2004 to FY 2007, the number of research and intervention projects using surveillance information has varied due to changes in the total number and types of projects funded each fiscal year. Although not included in the target, many CDC projects such as training initiatives and information projects are also initiated in response to surveillance information. CDC continuing education courses, CDC Alerts and Fact Sheets may be developed for occupational safety and health professionals, employers and employees to renew concern and present prevention strategies for identified workplace hazards.

The continued use of surveillance information in developing and evaluating projects and other OSH activities has been encouraged by the sector-based approach of the second decade of National Occupational Research Agenda (NORA) and the comprehensive NA reviews. Both of these initiatives urge scientists to analyze OSH surveillance data, and conduct projects that are relevant to existing OSH hazards and will result in a reduction in workplace illness and injury.

Long Term Objective 12.1, Performance Measure 3:

As part of the NA comprehensive review of research activities referenced above and NORA, all programs will develop comprehensive outcome-based measures and targets in conjunction with stakeholders and customers. These two initiatives have assisted CDC in exceeding this performance goal from FY 2005 to present. To date, NIOSH research programs have established Steering Committees which are currently drafting or finalizing strategic plans, including goals, measures and targets. In FY 2007, the Steering Committees had completed outcome measures and targets for 61 percent of CDC's programs – mining, construction, agriculture, health care and

transportation. These measures and targets guide the research programs in conducting customer-based, transparent research, and aid the NA committees in their evaluation of the impact of the research programs.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 12.2: Promote safe and healthy workplaces through interventions, recommendations and capacity building.										
12.2.1	Increase the percentage of CDC NIOSH-trained professionals who enter the field of occupational safety and health after graduation.	75% (Exceeded)	80% (Exceeded)	80%	80% (Met)	80%	85% (Exceeded)	80%	80%	N/A
12.2.2	Reduce the annual incidence of work injuries, illnesses, and fatalities, in targeted sectors. [O][1] A) Reduction of non-fatal injuries among youth ages 15–17. B) Reduction of fatal injuries among youth 15–17. C) Percentage of active underground coal mines in the U.S. that possesses NIOSH-approved plans to perform x-ray surveillance for pneumoconiosis.	A) 4.7/100 FTE (Exceeded); B) 2.3/100,000 FTE (Exceeded); C) 93% (Exceeded)	A) 4.1/100 FTE (Exceeded) B) 2.7/100,000 FTE (Exceeded) C) 94% (Exceeded)	A) 4.8/100 FTE B) 3.2/100,000 FTE C) 90%	A) 4.4/100 FTE (Exceeded) B) 3.2/100,000 FTE (Met) C) 92% (Exceeded)	A) 4.4/100 FTE B) 2.5/100,000 FTE C) 90%	A) 4.4/100 FTE (Met) B) 2.0/100,000 FTE (Exceeded) C) 94% (Exceeded)	A) 4.4/100 FTE B) 2.5/100,000 FTE C) 90%	A) 4.4/100 FTE B) 3.0/100,000 FTE C) 90%	N/A
12.2.3	Reduce occupational illness and injury as measured by: A) Percent reductions in respirable coal dust overexposure. B) Percent reduction in fatalities and injuries in roadway construction. C) Percent of firefighters and first responders' access to chemical, biological, radiological, and nuclear respirators. [O]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	A) 50% reduction B) 40% reduction C) 75% reduction (FY 2014)
12.2.4	Percentage of: A) Companies employing those with NIOSH training that rank the value added to the organization as good or excellent. B) Professionals with academic or continuing education training. [O]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	A) 80% B) Increase of 15%	N/A

[1] Sub-targets A and B of this measure have been incorporated in to the newly revised HHS strategic plan. Changes to the sub-targets above reflect revisions made during this process.

Long Term Objective 12.2, Performance Measure 1:

This measure focuses on the effectiveness of CDC training with respect to entry into the field of occupational safety and health. CDC conducts a competitive training grant program aimed at increasing the number of professionals trained to work in the occupational safety and health field. CDC supports a network of Education and Research Centers (ERCs) and Training Project Grants (TPGs) around the country. In FY 2007, 461 professionals graduated from these programs with specialized training in disciplines that include occupational medicine, occupational health nursing, industrial hygiene, occupational safety, and other closely related occupational safety and health fields of study.

CDC estimates that about half of all U.S. occupational safety and health professionals graduate from CDC-supported programs at the masters and doctoral levels. In FY 2007, CDC exceeded its performance goal with 85 percent of the professionals graduating from CDC-funded programs pursuing careers in occupational safety and health. The increase in demand for OSH professionals and the agency's ability to provide needed OSH training opportunities via the ERC/TPG network has enabled CDC to meet and exceed performance targets over the past several years.

Long Term Objective 12.2, Performance Measure 2:

CDC translates occupational safety and health surveillance and research findings into technically and economically usable solutions to control workplace hazards and reduce work-related injuries, illnesses, and fatalities.

CDC has a long history of conducting and supporting young worker safety and health research and intervention activities, and working with partners to improve young worker safety and health. The agency has exceeded and met the respective FY 2007 performance targets as rates of fatal and nonfatal injuries among young workers appear to be declining. Contributors to the reductions in young worker injuries include increased awareness of the issue and recent changes in child labor laws. In FY 2007, CDC, CDC grantees and others, finalized and disseminated OSH curricula that will increase young workers' basic knowledge of workplace safety and health. The curricula engages students and teachers in the exploration of risks to youth in the workplace, their rights and relevant labor laws, common workplace hazards and controls, communication skills, and young workers' role in emergency preparedness and response. CDC has also made valuable contributions in the area of child labor laws. The agriculture sector accounts for more work-related deaths of youth than any other industrial sector. In 2006, CDC produced previously unavailable data to help guide prevention efforts in the agricultural sector and led a federal interagency working group on childhood agricultural injury prevention. CDC also provided input into the revised child labor regulations that became effective February 14, 2005. Further progress was made on April 17, 2007, when the Department of Labor proposed federal child labor laws that will prohibit youth less than 18 years of age from working in poultry slaughtering and packaging plants, riding on a forklift as a passenger, fighting forest fires, and operating certain power-driven hoists and work assist vehicles. These regulatory changes are responsive to specific science-based recommendations made by CDC.

A new indicator regarding pneumoconiosis has been added to this measure. Coal production is increasing in the U.S., as it is an important alternative to foreign energy sources. Based upon Mine Safety and Health Administration (MSHA) data, in 2005 there were 49,395 employees in underground coal mines and 45,270 employees in surface coal mines, for a total of 94,665. This was an increase of 6,432 employees compared to 2004. The Energy Information Administration of the Department of Energy estimated in its Annual Energy Outlook 2006 document's Coal Forecast that employment in coal mining would rise by 27,000 between 2004 and 2030.

Pneumoconiosis and other dust-induced lung diseases, such as Chronic Obstructive Pulmonary Disease, are serious and potentially lethal disorders. According to the National Occupational Respiratory Mortality System, coal workers' pneumoconiosis was a causal or contributing factor in 703 deaths in 2004, the most recent year for which mortality data exists. Although there have been marked reductions in disease prevalence since the early 1970s, surveillance studies have demonstrated the existence of geographic "hot spots" for progressive pneumoconiosis. Furthermore, recent surveys have documented that young miners in their 30s and 40s, who have worked entirely under current dust regulations, continue to be stricken by rapidly progressive and advanced pneumoconiosis. Finally, ongoing radiographic surveillance shows increasing prevalence of disease in recent years. Among those with greater than 25 years of tenure in coal mining, in 1970 - 1974, 31.9 percent of surveilled miners had evidence of pneumoconiosis; in 1995 - 1999, 4.2 percent; and in 2005 - 2006, prevalence increased to 8.9 percent.

CDC has exceeded the 90 percent target level since the FY 2003 baseline year, but 90 percent remains an ambitious target for several reasons. Because pneumoconiosis continues to occur, it will be important to maintain high levels of participation among coal mines in CDC's Coal Workers Surveillance Program because of production demands, it is anticipated that many new coal mines will open that will need to be entered into the program. CDC has exceeded the 90 percent target level since the 2003 baseline year, but 90 percent remains an ambitious target for several reasons. CDC will work to encourage coal mines to participate by establishing surveillance plans in two ways: directly contacting mines without approved programs and assist them in developing approved programs, and partnering with the MSHA by informing them of mines without approved plans. MSHA has the ability to follow up with these mines to encourage participation, and if necessary, is able to issue citations to mines without plans and vacate the citations once plans are established.

Long Term Objective 12.2, Performance Measure 3:

For most program activities, reductions in occupational illnesses and injuries are due to multiple factors of which research is one component. However for some sectors and activities, extenuating circumstances are minimal and efforts are at a stage where future decreases in illness and injuries logically can be attributed to the success of programs without requiring the additional level of analysis. This measure targets three such high risk sectors and activities which represent impact in (1) occupational illness (due to coal dust overexposure); (2) occupational injuries (in roadway construction); and (3) preparedness (firefighter access to CBRN respirators). In FY 2003, the baseline for each was established: (1) greater than 15 percent; (2) 154 percent; and (3) greater than 7 percent. CDC will report on this long term measure in FY 2014.

Long Term Objective 12.2, Performance Measure 4:

The impact of training can be evaluated as a product of two metrics: the number of trained professionals in occupational safety and health positions, and the value of these trainees to their organizations. In addition, a third metric is used to judge the success of training programs based on the satisfaction of trainees. New surveys will be conducted to augment existing data on the impact of training programs. Follow-up surveys with trainees will determine their level of satisfaction with their education, and surveys of companies hiring trainees will judge the impact they are having in the workplace. In addition, efforts will continue to track the number of professionals with occupational safety and health duties that have academic or continuing education training. In FY 2003 the baseline for this measure was established, with 1,405 full-time academic trainees, 31,508 continuing education trainees and 68 percent of companies employing NIOSH-trained employees reporting favorably regarding value added to their organization. CDC will report progress made on this long term measure in FY 2009.

GLOBAL HEALTH

GLOBAL AIDS PROGRAM

CDC's Global AIDS Program (GAP) has offices in nearly 30 countries as part of coordinated interagency U.S. Government (USG) teams implementing the President's Emergency Plan for AIDS Relief (PEPFAR). GAP supports more than 37 additional countries through its headquarters and regional offices. GAP assists with HIV prevention, care and treatment; laboratory capacity building; surveillance, monitoring and evaluation; and public health evaluation research through partnerships with host governments, ministries of health (MOH), non-governmental organizations, international organizations, U.S.-based universities, and the private sector to help implement PEPFAR, including support for the Global Fund. GAP is uniquely positioned to coordinate with CDC's other global health programs, such as Global Disease Detection (GDD), public health training, and prevention and control of other infectious diseases such as malaria and tuberculosis, as well as with CDC's domestic HIV/AIDS prevention programs in the U.S.

As a part of the comprehensive USG Global HIV/AIDS strategy, GAP has worked closely with partners including United States Agency for International Development (USAID) and other government agencies, WHO, the World Bank, and others to develop a set of common core indicators of progress. A monitoring and evaluation plan for all activities has been developed and all countries report on core indicators of progress on an annual basis.

In 2005, OMB conducted a PART review of PEPFAR. The Office of the Global AIDS Coordinator (OGAC) of the U.S. Department of State coordinated the review, which included activities by HHS, CDC/GAP, HRSA, NIH, USAID, Peace Corps, and the Departments of Defense, State, Labor, and Commerce. OMB conducted separate PART reviews of the focus country programs, other bilateral programs, and Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) activities. As a result of this review, beginning in the FY 2007 budget cycle, GAP has included performance measures for focus country programs and other bilateral programs that reflect the USG-wide efforts under PEPFAR.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 13.A.1: GAP will help implement PEPFAR in 15 focus countries by partnering with other USG agencies to achieve the goals of treating 2 million HIV-infected people and caring for 10 million people infected with or affected by HIV/AIDS by 2008, and preventing 7 million new HIV infections by 2010.										
13.A.1.1	Number of people receiving HIV/AIDS treatment.	235,000 (Exceeded)	401,233 (Unmet)[1]	665,000	822,000 (Exceeded)	860,000	1,358,375 (Exceeded)	1.3 million	2 million	N/A
13.A.1.2	Number of individuals provided with general HIV-related palliative care/basic health care and support during the reporting period, including TB. [O]	854,800	1,397,555 (Unmet)	2,496,157	2,464,063 (Unmet)[1]	3,130,341	3,901,543 (Exceeded)	TBD[2]	TBD[2]	N/A
13.A.1.3	Number of pregnant women receiving PMTCT services, including counseling and testing during the reporting period.	1,271,300	1,957,932 (Unmet)	2,100,292	2,837,409 (Exceeded)	2,916,379	4,011,797 (Exceeded)	TBD[2]	TBD[2]	N/A
13.A.1.4	Number of individuals who received counseling and testing during the reporting period (counseling includes the provision of test results to clients	1,791,900	4,653,257 (Exceeded)	5,590,762	6,426,120 (Exceeded)	7,671,789	10,580,699 (Exceeded)	TBD[2]	TBD[2]	N/A

[1]These targets are set by the US Office of the Global AIDS Coordinator and represent the total USG contribution to achieving this goal. As a result, CDC cannot provide an explanation for not meeting this USG-wide target.
[2]Targets are established for entire USG efforts by the OGAC. OGAC has not released target numbers for USG measures for focus countries for those marked "TBD."

Long Term Objective 13.A.1, Performance Measure 1:

With the support of PEPFAR, approximately 50,000 individuals are added each month to the number of people benefiting from life-extending antiretroviral therapy (ART). The number of sites providing treatment increased by 139 percent from FY 2005 to FY 2006, and each month an average of about 93 new ART sites began operations. The baseline 2003 numbers are an aggregate of totals from different population-based studies conducted from 1998-2002 in 14 original countries (a subset of the focus countries).

The number of individuals receiving HIV/AIDS treatment has significantly increased from 66,911 in 2003 to 1,358,375 in FY 2007. The actual performance for Measure 1 was 1,358,375 individuals receiving treatment compared to the target of 860,000.

Long Term Objective 13.A.1, Performance Measure 2:

Palliative care comprises a broad range of services including physical, psychological, spiritual, and social support services. Please note that beginning in FY 2006, both target and actual number include TB (FY 2004 and FY 2005 did not include TB in either target or actuals).

The number of individuals provided with general HIV-related palliative care/basic health care and support has significantly increased from 854,800 in FY 2004 to 3,901,543 in FY 2007. The actual performance for Measure 2 was 3,901,543 individuals provided with care compared to the target of 3,130,341.

Long Term Objective 13.A.1, Performance Measure 3:

In FY 2004 through FY 2007, PEPFAR: (1) supported prevention of mother-to-child HIV transmission (PMTCT) services for women during more than ten million pregnancies; (2) supported antiretroviral prophylaxis for 533,700 HIV-positive pregnant women, averting an estimated 152,000 infant HIV infections; and (3) supported approximately 4,863 service outlets for prevention of mother-to-child HIV transmission. This is a program level indicator that is standardized across the 15 focus countries.

The number of pregnant women receiving PMTCT services has significantly increased from 1,271,300 in FY 2004 to 4,011,797 in FY 2007. The actual performance for Measure 3 was 4,011,797 pregnant women receiving these services compared to the target of 2,916,379.

Long Term Objective 13.A.1, Performance Measure 4:

PEPFAR supports efforts of host nations to dramatically expand HIV counseling and testing services. PEPFAR supports HIV counseling and testing, where consent is obtained and testing is performed in accordance with international standards. Within these standards, countries use a range of services to meet their specific needs. Client-initiated or self-referred counseling and testing is requested by an individual. In a medical setting, provider-initiated counseling and testing occurs when health care workers recommend an HIV test and the patient chooses to accept. This is a program level indicator standardized across the 15 focus countries.

The number of individuals receiving counseling and testing (including the provision of test results to clients) has significantly increased from 1,791,900 in 2004 to 10,580,699 in 2007. The actual performance for Measure 4 was 10,580,699 individuals compared to the target of 7,671,789.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 13.A.2: The Global AIDS Program will help implement the President's Emergency plan for AIDS Relief in the other bilateral countries by partnering with other USG agencies , international and host country organizations to achieve the goals of preventing new HIV infections, treating HIV-infected people, and caring for people infected with or affected by HIV/AIDS.										
13.A.2.1	Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites).	20,774	69,766[1] (Exceeded)	43,859	165,964 (Exceeded)[1]	306,053	276,965 (Unmet)	393,349	TBD[2]	N/A
13.A.2.2	Number of individuals trained to provide laboratory-related activities.	1,488	1,772 (Exceeded)	1,770	6,252 (Exceeded)	4,652	3,988 (Unmet)	TBD[2]	TBD[2]	N/A
13.A.2.3	Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results.	145,133	603,913[3] (Unmet)	633,185	1,108,500 (Exceeded)	TBD[2]	TBD[2]	TBD[2]	TBD[2]	N/A

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
13.A.2.4	Number of individuals who received counseling and testing during the reporting period.	773,649	1,710,048 (Exceeded)	1,049,628	2,478,262 (Exceeded)[1]	4,096,661	5,249,131 (Exceeded)	4,800,911	TBD[2]	N/A

[1]These results were updated in August 2007 per information received from OGAC.
[2]Targets are established for entire USG efforts by the OGAC. OGAC has not released targets numbers for USG measures for other bilateral programs in boxes marked "TBD."
[3]This data was generated before the other bilateral countries received any specific guidance on monitoring and evaluation from OGAC. Hence, indicator values for certain programmatic activities appear low or non-existent due to lack of available existing data. Indicators include data from CDC, USAID, Peace Corps, and Department of Defense (DoD) and are based on each agency's existing indicators for reporting which were mapped into PEPFAR indicators. The reported indicators are a subset of the full set of PEPFAR indicators, i.e., only those for which FY 2005 USG data is available.

Long Term Objective 13.A.2, Performance Measure 1:

In addition to the 15 focus nations, the PEPFAR now partners with 19 host nations to support ART for approximately 277,000 people. USG programs in these nations largely provide critical support through system-strengthening and capacity-building, including technical assistance to international partners that support treatment. This measure represents a program level indicator that is standardized for use across all other bilateral countries receiving $1 million or more in FY 2005 USG HIV/AIDS funding. Data from FY 2004 and FY 2005 are from USAID and HHS/CDC and were not under the guidance of PEPFAR reporting; therefore, double counting may exist due to overlap between agency programs.

The number of individuals receiving ART (including PMTCT+sites) through bilateral country programs has significantly increased from 20,774 in 2004 to 276,965 in 2007. The actual performance for Measure 1 was 276,965 individuals compared to the target of 306,053.

Long Term Objective 13.A.2, Performance Measure 2:

PEPFAR supports system-strengthening (including laboratories and surveillance and information systems), capitalizing on USG expertise in technical assistance and capacity-building for quality improvement and sustainability of programs. This measure represents a program level indicator that is standardized for use across all other bilateral countries receiving $1 million or more in USG HIV/AIDS funding in FY 2005. Data from FY 2004 and 2005 are from CDC and were not under the guidance of PEPFAR reporting. FY 2006 is the first reporting cycle that PEPFAR guidance is in effect for the countries receiving $1 million or more in USG HIV/AIDS funding.

The number of individuals trained to provide laboratory-related activities increased sharply from 1,488 in FY 2004 to 6,252 in FY 2006 before declining to 3,988 in FY 2007. The actual performance for Measure 2 was 3,988 individuals trained compared to the target of 4,652.

Long Term Objective 13.A.2, Performance Measure 3:

Through PEPFAR, the USG will continue to support counseling and testing for pregnant women, emphasizing the provision of tests results. This measure represents a program level indicator that is standardized for use across all other bilateral countries receiving $1 million or more in USG HIV/AIDS funding in FY 2005. Data from FY 2004 and FY 2005 are from USAID and HHS/CDC and were not under the guidance of PEPFAR reporting. Therefore, double counting may exist due to overlap between agency programs. FY 2006 is the first reporting cycle that PEPFAR guidance was in effect for the countries receiving $1 million or more in USG HIV/AIDS funding.

The number of pregnant women receiving HIV counseling and testing for PMTCT and their test results has significantly increased from 145,133 in 2004 to 1,108,500 in 2006. The actual performance for Measure 3 was 1,108,500 pregnant women compared to the target of 633,185.

Long Term Objective 13.A.2, Performance Measure 4:

PEPFAR supports programs to care for persons living with HIV/AIDS (PLWHA) and to provide HIV counseling and testing in a growing number of countries. This measure represents a program level indicator that is standardized for use across all other bilateral countries receiving $1 million or more in USG HIV/AIDS funding in FY 2005. Data from FY 2004 and 2005 are from USAID and HHS/CDC and were not under the guidance of PEPFAR reporting. Therefore, double counting may exist due to overlap between agency programs. FY 2006 is the first reporting cycle that PEPFAR guidance was in effect for the countries receiving $1 million or more in USG HIV/AIDS funding.

The number of individuals receiving counseling and testing as a result of bilateral country programs has significantly increased from 773,649 in 2004 to 5,249,131 in 2007. The actual performance for Measure 4 was 5,249,131 individuals compared to the target of 4,096,661.

GLOBAL IMMUNIZATION PROGRAM

In 2005, the Global Immunization Program underwent OMB's PART review process. New performance measures were developed as a result and are included below in the tables and narrative.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	FY 2015 Target
				Target	Actual	Target	Actual			
Efficiency Measure										
13.B.E.1	The portion of the annual budget that directly supports the program purpose in the field.	93% (Baseline)	93% (Exceeded)	>=90%	91% (Exceeded)	>=90%	4/2008	>=90%	>=90%	N/A

Efficiency Measure 13.B.E.1:

Developed through the 2005 PART process, this measure demonstrates that the majority of the Global Immunization Program's funding is used to support mission-critical activities directly through CDC's global partners, the WHO, UNICEF, PAHO and UNF. Specifically, these funds are used to purchase measles and polio vaccine and/or to provide technical or operational support through these agencies. CDC will maintain this efficiency and support for these activities in order to continue to meet global health goals.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 13.B.1: Help domestic and international partners achieve World Health Organization's goal of global polio eradication.										
13.B.1.1	Number of doses of oral polio vaccine (OPO) purchased for use in OPV mass immunization campaigns in Asia, Africa, and Europe (1 dose = 1 child reached).	500 million doses (Met)	428 million doses (Unmet)	500 million doses	341 million doses (Unmet)	260 million doses	287 million (Met)	240 million doses	240 million doses	N/A
13.B.1.2	Number of children reached with OPV as a result of non-vaccine operational support funding provided to implement OPV mass immunization campaigns in Asia, Africa, and Europe.[1]	N/A	N/A	Baseline	37 million children	100 million children reached	6/2008	60 million children reached	45 million children reached	N/A
13.B.1.3	Number of countries in the world with endemic wild polio virus. [O]	6 endemic countries	5 endemic countries (Met)	4 endemic countries	4 endemic countries (Met)	3 endemic countries	8/2008	0 endemic countries	0 endemic countries	N/A

[1]The proposed target for children reached in FY 2008 is based on projected level funding. The target for FY 2007 is significantly higher, due to a shift in the funding period for WHO which enabled CDC to allocate additional funds to offset a part of the SIA operations funding shortfall.

Long Term Objective 13.B.1, Performance Measure 1:

CDC continues to be one of the Global Polio Eradication Initiative's (GPEI) largest procurers of Oral Polio Vaccine (OPV). CDC works in partnership with WHO and UNICEF to ensure that CDC funding is used to fill critical unmet needs for the global initiative. The FY 2006 target for OPV procurement was not met, due to a number of programmatic reasons, including:

- The cost of OPV has increased 26 percent from FY 2004 ($0.10/dose) to FY 2006 ($0.126/dose). Average costs to date in FY 2007 are $0.14/dose.
- WHO and UNICEF have successfully mobilized new donor contributions to the GPEI, especially for OPV procurement. While critical OPV funding gaps have been filled, significant funding gaps remain for the extensive program operations required to reach children during supplemental immunization activities (SIAs) (transport, vaccinators, cold chain management). The average cost to reach a child during SIAs is $0.31/per child (variable by country). The availability of other donor support for OPV has allowed CDC to use its more flexible funding to fill critical SIA operational gaps, ensuring that the vaccines do indeed reach the child, as well as supporting outbreak response activities related to imported poliovirus.
- CDC support for SIA operations in FY 2006 allowed the GPEI to reach 37 million children for administration of OPV.

Long Term Objective 13.B.1, Performance Measure 2:

The GPEI faces substantial funding gaps for SIAs in FY 2007 and FY 2008. A number of donors, including Japan and Germany, have recently announced new donations for OPV, covering the majority of the unmet vaccine needs. CDC, WHO and UNICEF have ongoing dialogue regarding CDC funding allocations. During a consultation meeting at UNICEF in July 2007, CDC was asked to shift approximately $13 million from the purchase of OPV to operational costs to avert an emerging funding crisis.

As a result, the Global Immunization Division (GID) proposed a broader indicator that captures the number of children reached with CDC funding, both through OPV procured and the operations required to get vaccines to children. This would be done using the existing performance measure related to vaccine procurement, supplemented by this new measure related to the number of children reached through CDC SIA operations funding.

In November 2007, Rotary International announced a partnership with the Bill and Melinda Gates Foundation that will provide $200 million into the global campaign to eradicate polio over the next three years. This helped to reduce the funding gap for 2007-2008 to $265 million with a further $220 million needed for 2009. Updated funding requirements for the GPEI will be published in January 2008.

Long Term Objective 13.B.1, Performance Measure 3:

Global polio incidence declined by more than 99 percent from 1988 to 2006. The number of endemic countries reduced from 125 polio-endemic countries in 1988 to four countries (Afghanistan, India, Nigeria, and Pakistan). In 2006 more than 94 percent of cases reported globally were from these four endemic countries. Provisional data indicate that as of December 2007 there has been a 53 percent decrease in cases from the endemic countries as compared with the same period in 2006 with the most dramatic decreases seen in Nigeria and Afghanistan. This decrease is largely due to the widespread use of monovalent OPV type 1, which provides greater protection against the Type 1 poliovirus. (Type 1 polio causes higher disease burden and has greater potential to spread globally.) Transmission of Type 1 polio has

decreased by 89 percent in Nigeria and 88 percent in India as compared with 2006 (data as of December 31, 2007). In addition to the endemic countries, 13 countries reported cases due to importations and subsequent transmission in 2006. Implementation of new guidelines for response to importations appear to have effectively limited transmission in five of the 13 from which no polio cases have been reported to date in 2007. However, importations and subsequent spread in the Democratic Republic of Congo, Chad, and Niger are of concern. Nevertheless, as a result of the polio eradication initiative, 250,000 lives have been saved and five million cases of childhood paralysis have been prevented.

Three of the six WHO Regions (the Americas, Western Pacific and European Regions) have achieved and maintained regional elimination of polio, with elimination certified in 1994, 2000, and 2002 respectively. Despite progress in the endemic countries, ongoing transmission is likely to delay global polio eradication until 2008. As long as polio transmission occurs anywhere in the world, it remains a threat to American children. CDC will continue to fight polio by collaborating with partners to increase the number and quality of National Immunization Days and intensify implementation of the other strategies to interrupt transmission. CDC will continue to provide scientific assistance to improve tracking to certify that polio eradication has occurred.

This measure is an adaptation developed as a result of the 2005 PART process and serves as both a long term and annual measure. The ultimate objective is to eradicate polio. The previous goal tracked cases of polio, whereas the new goal tracks number of countries with endemic polio.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 13.B.2: Work with global partners to reduce the cumulative global measles-related mortality by 90% compared with 2000 estimates (baseline 777,000 deaths) and to maintain elimination of endemic measles transmission in all 47 countries of the Americas.										
13.B.2.1	Number of global measles-related deaths. [O]	N/A	345,000 (Exceeded)	399,200	242,000 (Exceeded)	363,400	12/2008	327,600	291,800	77,700 (FY 2015)
13.B.2.2	Number of non-import measles cases in all 47 countries of the Americas as a measure of maintaining elimination of endemic measles transmission. [O]	78 (Unmet)	0 (Met)	0	0 (Met)	0	6/2008	0	0	N/A

Long Term Objective 13.B.2, Performance Measure 1:

CDC provided scientific, technical, and programmatic support for measles outbreak investigations in Pakistan, Tanzania, Kenya, Sudan, Georgia and the Ukraine; supported reviews of immunization surveillance in the African and Western Pacific regions and a national review in the Republic of the Maldives and the Philippines; helped conduct a review of accelerated measles control activities in the western provinces of China; and evaluated the regional surveillance system for measles, rubella and congenital rubella syndrome in the American and European regions. CDC also contributed funding and or technical assistance to measles immunization campaigns in 23 African countries and to those planned and conducted in Afghanistan, Armenia, Bangladesh, Bhutan, Fiji Indonesia, Pakistan, Yemen, and others. These efforts resulted in recommendations for improved surveillance and control activities and contributed substantially to declines in measles mortality.

Measles has been eliminated from the Western Hemisphere. Outstanding progress has been made towards reducing measles mortality globally. In January 2007, the Measles Partnership

announced that the goal for 50 percent global measles mortality reduction by 2005 (from 1999 levels) had been surpassed and a 60 percent reduction in measles mortality achieved. Most significant reductions were seen in the African region, where a 91 percent reduction was achieved due to implementation of the measles mortality reduction strategies. These achievements highlight the technical feasibility of measles mortality reduction. By 2010 CDC and global immunization partners aim to reduce the global measles-related mortality by 90 percent compared with this estimate from 2000. CDC's contributions to the achievements in the African Region were recognized with a special award at the African Region Task Force on Immunization (TFI) meeting in December 2007.

The model used to generate the preceding year coverage is based on routine and campaign related performance data that is captured by a joint WHO/UNICEF reporting form. WHO and UNICEF convene a panel committee to review this data annually and reach consensus on estimates of disease burden.

Long Term Objective 13.B.2, Performance Measure 2:

This performance measure corresponds with the goal adopted by the PAHO for Latin America and the Caribbean. According to available surveillance information, measles transmission has been interrupted in all countries of the Western Hemisphere since November 2002. However, imported measles cases, with limited secondary spread, continue to occur in several countries, including the U.S. Deaths from measles complications in the Americas have virtually disappeared. Globally, measles caused an estimated 242,000 deaths in 2006 and was the leading cause of death among children under five years of age from a vaccine-preventable disease.

PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP

OFFICE OF MINORITY HEALTH AND HEALTH DISPARITIES

The Office of Minority Health and Health disparities provides leadership support, technical assistance, and scientific support to CDC programs and external partners on public health activities that will lead to the elimination of health disparities.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 14.B.1: Prepare minority, medical, veterinary, pharmacy, undergraduate, and graduate students for careers in public health.										
14.B.1.1	Increase the number of minority students participating in the Hispanic Serving Health Professions Internship and Fellowships Program, Ferguson Emerging Infectious Disease Fellowship Program, Public Health Summer Fellowship Program, Research Initiatives for Student Enhancement (RISE) and Project IMHOTEP.	95 (Exceeded)	101 (Exceeded)	87	106 (Exceeded)	87	106 (Exceeded)	95	95	N/A

Long Term Objective 14.B.1, Performance Measure 1:

In FY 2007, the target was exceeded because of new programs with Kennedy Krieger Institute/RISE, and Morehouse College/IMHOTEP programs which provided opportunities for additional students. Although the trend of exceeding the target has been consistent for the past four years, the target will not be set upward because additional dollars to expand programs are not expected. Additionally, supplemental funding from other CDC programs to support minority student internships is increasingly difficult to identify.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 14.B.2: Support HBCUs, Hispanic serving institutions, and Tribal Colleges and Universities (TCUS).										
14.B.2.1	Maintain the number of funding mechanisms and increase the number of minority-serving institutions and TCUs receiving support.	4 cooperative agreements (Met); 70 schools (Exceeded)	4 cooperative agreements (Unmet); 76 schools (Exceeded)	4 cooperative agreements; 47 schools	4 cooperative agreements; (Met) 48 schools (Exceeded)	4 cooperative agreements; 47 schools	4 cooperative agreements; (Met) 48 schools (Exceeded)	4 cooperative agreements; 50 schools	4 cooperative agree-ments; 52 schools	N/A

Long Term Objective 14.B.2, Performance Measure 1:

In FY 2007, a total of 48 schools were reached, exceeding the target by one school. (The targeted number of institutions projected for FY 2007 and FY 2008 were decreased because the Tribal Colleges and Universities (TCU) cooperative agreement, representing 33 institutions, expired at the end of FY 2005.)

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 14.B.3: Enhance American Indian/Alaskan Native (AI/AN) access to CDC programs and resources and foster a stronger collective departmental perspective on AI/AN issues.										
14.B.3.1	Participate in the HHS National and Regional Tribal Consultation Sessions to strengthen CDC and HHS partnerships with tribes to accelerate health impact and address health disparities in AI/AN populations.	N/A	N/A	N/A	N/A	Hold 2 tribal consultations	Met	Hold 4 tribal consultations	Hold 8 tribal consultations	N/A
14.B.3.2	Maintain support for, and effective communication with the CDC/ATSDR Tribal Consultation Advisory Committee (TCAC).	N/A	N/A	N/A	N/A	Hold 4 meetings and act on 2 tribal recommendations	Met	Hold 4 meetings and act on 5 tribal recommendations	Hold 4 meetings and act on 8 tribal recommendations	N/A
14.B.3.3	Categorize, systematically monitor, and critically assess CDC resources allocated to programs that directly benefit AI/AN people and communities.	N/A	N/A	N/A	N/A	Maintain 2 IAAs and attend 2 meetings of each council	Met	Maintain 2 IAAs and influence one Council activity important to CDC's work with AI/ANs	Maintain 2 Interagency Agreements (IAAs) and influence 2 Council activities important to CDC's work with AI/ANs	N/A
14.B.3.4	Participate and support the Interagency Agreement for the Intradepartmental Council on Native American Affairs and the HHS AI/AN Research Council.	N/A	N/A	N/A	N/A	Maintain 2 IAAs and attend 2 meetings of each Council	Met	Maintain 2 IAAs and influence on Council activity important to CDCs work with AI/ANs	Maintain 2 IAAs and influence 2 Council activities important to CDCs work with AI/ANs	N/A

Long Term Objective 14.B.3, Performance Measure 1:

In FY 2006, CDC established an official Tribal Consultation Policy (TCP) that: delineates procedures and responsibilities for tribal consultation; provides guidance to CDC staff on working effectively with AI/AN governments, communities and organizations; and enhances tribal access to CDC programs and resources. OMHD/OSI is responsible for ensuring agency-wide adherence to CDC and HHS tribal consultation policies and CDC participation in regional and national tribal consultation sessions. In June of 2007, CDC's Division of Diabetes

Translation consulted with tribal leader representatives from the 12 IHS Areas on the Native Diabetes Wellness Program ongoing projects, including the Eagle Books and the development of a new FOA. On April 5, 2007, the Occupational Safety and Health program convened a meeting of the AI/AN Cessation Expert Panel (tribal leaders from six different tribal Nations) as a follow-up to an effort designed to more fully understand approaches, measures, and tools for promoting tobacco cessation efforts among this population. Lessons learned and next steps were also addressed. CDC participated in the HHS National Budget and Consultation session and two HHS regional consultation sessions.

Long Term Objective 14.B.3, Performance Measure 2:

Established formally in FY 2007, the TCAC is an advisory committee to the CDC Director and ATSDR Administrator wherein tribal representatives and CDC leadership exchange information about urgent public health issues in Indian country and collaborate on approaches to address these issues and needs. The TCAC also helps to ensure that CDC activities or policies that affect tribal communities are brought to the attention of tribal leaders and, through its recommendations to CDC, serves to facilitate collaboration across the agency on a continuum of prevention and health protection actions that support CDC's health protection goals for AI/AN populations. The TCAC held three additional formal meetings in FY 2007 to increase the connectivity and knowledge between CDC and tribal leaders (October 9, 2006; November 2-3, 2006; January 30-31, 2007; July 11-12, 2007). The TCAC submitted recommendations to the CDC Director and ATSDR Administrator to inform them of and to address critical public health issues in Indian country. An inventory of CDC response to recommendations can be found at http://www.cdc.gov/omhd/TCAC/Recommendations.html.

Long Term Objective 14.B.3, Performance Measures 3 and 4:

In FY 2003 through FY 2006, CDC developed improved procedures for tracking how its resources are allocated to benefit AI/AN populations. The annual reports produced from these data have enhanced accountability and increased transparency regarding how CDC programs and resources are made available to AI/AN populations. In FY 2007, CDC funded 68 cooperative agreements to 48 tribal partners (tribal governments, tribal health boards, tribal organizations, Alaska Native health corporations, urban Indian health centers, and tribal colleges) across 19 states and the District of Columbia. CDC maintained two IAAs with the IHS and also the IAAs with the Interdepartmental Council on Native American Affairs (ICNAA) and HHS OMH/ AI/AN Health Research Advisory Council and did attend two council meeting of each in FY 2007. CDC OD will continue to support and participate actively in HHS-sponsored councils and committees to collaborate more effectively with other agencies to maximize resources and increase tribal access to CDC and HHS programs.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 14.B.4: Support and strengthen capacity development strategies of existing national and regional minority organizations.										
14.B.4.1	Increase the number of national and regional public health collaborations with public health agencies/organizations serving minority and AI/AN communities.	N/A	N/A	75	477 (Exceeded)	85	240 (Exceeded)	100	100	N/A
14.B.4.2	Identify program and organizational infrastructure needs (i.e., policy analysis, program assessment and development, and evaluation) of public health agencies/organizations serving minority communities and provide technical assistance to improve the health status and access to programs for racial and ethnic minority populations.	N/A	N/A	75	477 (Exceeded)	85	240 (Exceeded)	100	100	N/A

Long Term Objective 14.B.4, Performance Measures 1 and 2:

Programs funded under this measure support national and/or regional initiatives to develop, expand, and enhance health promotion, educational, and community-based programs targeting racial and ethnic populations. The seven cooperative agreements awarded to support and strengthen existing NMOs/RMOs that engage in health advocacy, promotion, education and preventive health care with the intent of improving the health and well-being of racial and ethnic minority populations have led to collaborations and technical assistance that benefited 240 entities.

OFFICE OF THE CHIEF OF PUBLIC HEALTH PRACTICE

PUBLIC HEALTH LAW PROGRAM

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 14.C.1: Develop the legal preparedness of the public health system to address public health emergencies and other national public health priorities.										
14.C.1.1	Complete national dissemination of the revised "Forensic Epidemiology" and "Public Health Emergency Law" training curricula.	N/A	N/A	N/A	N/A	Complete development of second editions of both curricula	Met	Complete field testing and begin national dissemination of both curricula	Complete dissemination of both curricula to all state public health agencies	N/A

Long Term Objective 14.B.1, Performance Measure 1:

A major strategic goal of the CDC's Public Health Law Program is to improve state and local public health agencies' legal preparedness for public health emergencies. Originally developed by the Program, the "Forensic Epidemiology" and "Public Health Emergency Law" public health law training curricula are central to this goal by strengthening public health practitioners' competencies in applying public health emergency legal authorities. The first editions of these curricula were developed in 2003 and 2005, respectively. At present, more than 13,000 public health and partnering law enforcement officials have completed "Forensic Epidemiology" training and "Public Health Emergency Law" has been delivered in the District of Columbia and in at least 30 states. The Program completed systematic revisions and enhancements to both curricula in 2007. Revisions reflect feedback from initial field delivery of both curricula as well as front-line legal preparedness "lessons learned" from the 2005 Hurricane Katrina response. National dissemination of the new, second editions will begin in 2008. Dissemination to all state public health agencies in FY 2009 will lead to improved public health legal preparedness competencies nationally.

PUBLIC HEALTH WORKFORCE DEVELOPMENT

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 14.D.1: CDC will develop and implement training to provide for an effective, prepared, and sustainable health workforce able to meet emerging health challenges.										
14. D. 1.1	Maintain the number of recruits who join public health programs in local, state, and federal health departments to participate in training in epidemiology or public health leadership management.	221 (Exceeded)	216 (Exceeded)	200	206 (Exceeded)	200	205 (Exceeded)	200	200	N/A

Long Term Objective 14.D.1, Performance Measure 1:

In response to an August 2003 report that identified public health workforce gaps at the state and local levels, CDC continues to train professional staff to address these gaps and investigate health problems affecting the nation's population, through its Epidemic Intelligence Service (EIS), its Preventive Medicine Residency and Fellowship (PMR/F), and the Public Health Prevention Service program.

The performance targets for the preceding measure were set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program performance. Note: In FY 2007, the FY 2004 result was revised from 258 to 221 to reflect fellows that were core-funded in FY 2004. The previous result inadvertently included EIS officers funded with non-core funds (e.g., Bioterrorism, Food Safety). Additionally, the FY 2005 through FY 2009 targets have been revised to remain constant, due to the creation of the Office of Workforce and Career Development (OWCD) in 2004 and uncertainty about the programs' ability to increase the number of health professionals recruited and/or trained.

The number of recruits in public health programs in local, state, and federal health departments participating in epidemiology or public health leadership and management has dropped slightly (7 percent) during the past four years, from a high of 221 in 2004 to a low of 205 in 2007, but remains higher than the target of 200. One reason for the reported decline is that the number of PMR applications has declined for several years, resulting in fewer PMRs during the past two years. Another reason for the reported decline is that the number of core-funded EIS officers has decreased as the number of officers funded with terrorism preparedness and emergency response (TPER) funds has increased. TPER funds allow the Public Health Workforce Development program to continue to train the same number of EIS officers each year.

To help accomplish the preceding goal, CDC is developing a Fellowship Management System, which is an electronic system designed to increase CDC's ability to monitor and track fellows in its 10 cross-cutting fellowship programs. Tracking alumni through a secure, online directory will 1) provide readily accessible contact information for alumni trained by the agency and possessing mission-critical skills in the event of a national public health emergency, 2) allow CDC to document the impact of the fellowships on the career paths of participants, and 3) allow alumni to maintain their professional networks for finding jobs, staffing jobs, and collaborating and interacting with other alumni. CDC also is researching the development of new fellowships designed to address the public health needs of the increasingly diverse U.S. population.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 14.D.2: Increase the number of frontline public health workers at the state and local level that are competent and prepared to respond to bioterrorism, infectious disease outbreaks, and other public health threats and emergencies; and prepare frontline state and local health departments and laboratories to respond to current and emerging public health threats.										
14.D.2.1	Evaluate the impact of training programs conducted by the NLTN on laboratory practices.	34% increase (Base-line) (Met)	Results Incon-clusive (Unmet)	90% of the public health and clinical laboratorians attending NLTN courses can correctly handle, process, or identify potential disease agents.	90% (Met)	More than 40% of public health and clinical laboratorians attending biosecurity practice NLTN courses who reported lacking practices for physical security/access control, information security and training/practice drills added these practices or modified current practices as a result of the course.	51% (Met)	More than 40% of public health and clinical laboratorians attending biosecurity practice NLTN courses who reported lacking practices for physical security/access control, information security and training/practice drills added these practices or modified current practices as a result of the course.	More than 40% of public health and clinical laboratorians attending biosecurity practice NLTN courses who reported lacking practices for physical security/access control, information security and training/practice drills added these practices or modified current practices as a result of the course.	N/A

Long Term Objective 14.D.2, Performance Measure 1:

The National Laboratory Training Network (NLTN) training and gathering of statistical data described below is continuing during FY 2007.

From October 2006 through September 30, 2007, the NLTN provided 324 classes and trained more than 32,000 public health and clinical laboratorians through cost-effective, high quality continuing education in the laboratory sciences. NLTN courses are available in a variety of formats, developed based on documented training needs, and delivered in collaboration with state public health laboratories. Course topics include bioterrorism and chemical terrorism preparedness; safe packaging and shipping of diagnostic and infectious agents; biosafety and biosecurity; antimicrobial susceptibility testing; and pandemic influenza preparedness. Selected courses from the previous year are evaluated to determine outcomes of training.

The performance targets for the preceding measure were set at approximate target levels, and the deviation from those levels is slight. There was no effect on overall program performance. Note: The previously submitted targets for 2007–2009 were revised to ensure that the targets are measurable. Results for the revised 2007 target were measured by a survey of those attending the courses.

NLTN is meeting its overarching goal by determining each year what training is needed by laboritorians at state and local levels, and providing that training. During the past several fiscal years, NLTN has steadily increased the number of course offerings and modified course offerings based on need. NLTN determines need by meeting with and listening to public health partners at state and local levels.

BUILDINGS AND FACILITIES

In addition to PART measures established in the 2004 review of Buildings and Facilities, CDC has implemented HHS-level Federal Real Property Council (FRPC) performance metrics. CDC used the following measures and definitions detailed in the memo, HHS Real Property Asset Management Program Performance Measures (DAS/OFMP, 8 SEP 2005), to assess its FY 2009 B&F budget submission described in the Program Narrative, as directed in the memo, Pre-Budget Guidance for the HHS Fiscal Year 2009 Budget (DAS/OFMP, 30 MAR 2006).

- Mission Dependency – An indication of the value an asset brings to the performance of the HHS/OPDIV mission.
- Facility Utilization – A quantitative assessment of the degree to which assets are utilized by asset type, including "Utilization Status," "Utilization Rate," and "Disposition Recommendation."
- Facility Condition – A quantitative assessment of how well an asset is being maintained in accordance with a systematic Sustainment and Improvement Strategy.
- Facility Cost – An assessment of the total operating and maintenance costs at the asset level, and positive project economics such as cash-flow or life-cycle cost analysis.

FRPC PERFORMANCE METRICS

Nationwide Repairs and Improvements (R&I) Program		
FRPC Measure	Impact	Explanation
Mission Dependency		
Mission Dependency	Positive	R&I funds will be used for "mission critical" and "mission dependent" facilities in accordance with CDC's Sustainment strategy. Repair funds are used to sustain buildings in an "operational status." Improvement funds are used to modify space to bring it into alignment with current codes and reduce "overutilized" space.
Facility Utilization		
Utilization Status	Positive	R&I funds will be used for "overutilized" and "utilized" facilities in accordance with CDC's sustainment strategy.
Utilization Rate	Positive	R&I funds are used to restore assets to a condition that allows their continued effective designated use, and to improve an assets functionality or efficiency, thus maintaining or improving the utilization of the asset.
Retention/Disposal	Positive	CDC intends to use R&I funds to demolish part of 47 identified underutilized, non-mission critical, underperforming assets between 2006-2010, that are not funded through major (Capital) projects, thereby improving portfolio utilization rates and reducing costs. An additional 13 assets have been identified for disposal by 2013.
Facility Condition	Positive	As shown in the Facility Condition Index table, R&I funding at these levels will support CDC's sustainment strategy to maintain portfolio CI=90 or better.
Sustainment and Improvement Strategy	Positive	CDC has a current (2007) estimated Building Maintenance Backlog Reduction (BMAR) of $27.2 million. This projection CDC feels, will allow CDC to return all assets to a CI equal to or grater than 90%.
Facility Cost		
O&M Cost	Positive	CDC anticipates a positive but unquantified impact on O&M costs resulting from sustainment-level R&I funding. Appropriate R&I and BSS funding will ensure that plant and equipment are operated and maintained in accordance with manufacturer's warranties, and to maximize energy and operating efficiencies.
Project Economics	N/A	

Sustainment Strategy Summary: Sustainment funding includes a combination of operations funded maintenance and minor renovations, and B&F funded repair, necessary to sustain the facility in its current condition. CDC funds sustainment through the internal Business and Services Support (BSS) activity (operations) and the nationwide Repairs and Improvements (R&I) Program (B&F).

Using data from the Automated Real Property Information System data base and individual Building Condition Assessments, CDC has projected R&I and BSS funding required from FY 2008 to FY 2013 inclusive, to improve and sustain CDC's owned assets at a minimum Condition Index (CI) of 90 as required by HHS. These projections take into account assets that CDC will propose to HHS for disposal based on the FRPC Disposition Decision Tree, as well as new assets approved, funded and under design/construction through FY 2007, and proposed assets identified in the Five-Year Plan with an out-year cost estimate (i.e., B24, B107, B108, and build-out of the Ft. Collins lab shell space). CDC's sustainment strategy incorporates the following measures:

- Base funding requests on periodically updated Facility Condition Assessments for each asset to achieve and maintain a minimum CI=90;
- Prioritize sustainment funding around mission critical assets that are appropriately utilized and can be operated and maintained in a cost effective manner;
- Continue to review the owned and leased inventory to identify assets for disposition in accordance with the FRPC's Disposition Decision Analysis framework (Please note that since the late 1990's, CDC has disposed of or earmarked for disposal over 40 non-performing assets nationwide); and,
- Continue to request recapitalization funding for new construction or modernization where appropriate to replace non-performing assets as described in the Five-Year Plan in the narrative section.

PART PERFORMANCE MEASURES

#	Efficiency Measure	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
15.E.1	Energy and water reduction. [E] Goals under EPAct '05 and E.O. 13423	Energy Baseline 0% (2003) Water Baseline 0% (2007)	N/A N/A	N/A N/A	N/A N/A	Energy 03% Water N/A	Energy 12.6% Reduction (Met) Water N/A	Energy 06%; Water 02%	Energy 09%; Water 04%	N/A N/A
	Goals under E.O. 13123	Water Baseline 0% (1990) Energy Baseline 0% (1990)	Water 09% (Unmet) Energy 18% (Unmet)	N/A N/A	N/A N/A	Energy N/A; Water 30%	Energy N/A Water +43% (Unmet)	N/A N/A	N/A N/A	N/A N/A
15.E.2	Deliver leased space below Atlanta's sub-market rate. [E]	N/A	-10% (Met)	10% under market	-10% (Met)	10% under market	N/A	10% under market	10% under market	N/A N/A

Efficiency Measure 15.E.1:

This table and its goals were initially set up for compliance under Executive Order (E.O.) 13123, which measures energy and water usage. CDC has not met these goals since FY 2004 because the agency has added significant square footage to its owned facilities through capital construction activities. FY 2007 is the last year that E.O. 13123 goals will be used because it has been superseded by E.O 13423. E.O. 13423 measures energy and water usage per square foot of space and is more useful for growing facilities. This new executive order has increased requirements and changed the baseline years for comparison. The E.O. 13423 energy reduction goal of 3 percent is valid for FY 2007. CDC significantly exceeded this goal with a 12.6 percent energy reduction because a number of new buildings have been constructed since 2003, each incorporating green building principles and energy efficient systems in order to attain LEED certification. CDC's annual report to HHS on the Energy Management and Conservation Program reflects these newer and more stringent goals. Active measures continue to be taken in order to comply with the latest federal and Department requirements.

CDC has met 75 percent of its energy goal. CDC is placing considerable emphasis on energy efficient design for its new labs, and this may result in lower future consumption. However, CDC may expect somewhat higher energy usage through the end of the projected construction period (FY 2009) as some older labs remain in service combined with additional electrical usage resulting from actual construction activities. However, as older buildings are taken out of service and new construction is completed, energy use per square foot will improve.

Efficiency Measure 15.E.2:

To demonstrate the most efficient use of taxpayer dollars, this measure will monitor leased space cost with the expectation of delivering quality space below sub-market rates. CDC used its market presence and sound negotiations to achieve below market lease rates. In 2003, the baseline year, CDC provided leased space at a rate of five percent under market. CDC has consistently met its targets since FY 2005. In FY 2007, CDC did not acquire any leased space in the Atlanta area, therefore this measure was not applicable. However, CDC plans to continue leasing space in the future with the goal of meeting the target set by this measure.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 15.1: Implement scheduled improvements, construction, security, and maintenance consistent with available resources and priorities identified in CDC's master facilities planning process.										
15.1.1	Aggregate of scores for capital projects rated on scope, schedule, budget, and quality.	N/A	=>90% (Met)	Greater than or equal to 90%	=>90% (Met)	Greater than or equal to 90%	=>90% (Met)	Greater than or equal to 90%	Greater than or equal to 90%	N/A
	- Roybal Campus East Campus Consolidated Lab Project, Bldg 23	Met (Pending Project and Funding Authority Approval)	Met	Continue design, Begin construction	Met	Complete design, Continue construction	Met (The Design Phase as reported was completed in Oct. 06)	Continue construction	Continue construction	N/A
	- Epi Tower, Bldg 24	Pending (Pending Project and Funding Authority Approval)	Pending (Pending Project and Funding Authority Approval)	Pending	TBD (Pending Project and Funding Authority Approval)	HHS Project Approval (design)	CIRB Approval 7/07; FPAA Approval expected 2/2008	TBD	TBD	N/A
	- Infrastructure and security upgrades, Bldg 20	N/A	Met	Continue construction	Met	Continue construction	Met	Complete Construction	N/A	N/A
	- Chamblee Campus Environmental Health Facility, Bldg 106	Met	Met	Complete design; Continue construction	Met	Complete Construction	Construction Complete Expected 12/2007	N/A	N/A	N/A
	-Cincinnati Campus Lab. Consolidation – Site Acquisition	Met (Pending Project and Funding Authority Approval) [1]	Met (Pending Project and Funding Authority Approval) [1]	Continue analyses	Met (Pending Project and Funding Authority Approval) [1]	Continue analyses	Analyses Completed in August, 2007 (met)	Continue analyses	N/A	N/A
	-Ft. Collins, CO Campus DVBID Replacement Laboratory	Met	Met	N/A	N/A	Complete Construction	Met	N/A	N/A	N/A
	-Ft. Collins, CO Campus -DVBID Shell Space	N/A	N/A	N/A	N/A	HHS Project Approval (Design and initiate construction)	FPAA Approved Expect Design/Build Award 4/2008	Continue Construction	Continue Construction	N/A

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
15.1.2	Placement of NCID & NCEH laboratorians in CDC standard space (Projects occupied or underway).	N/A	70%, 100% (Met)	NCID 70%; NCEH 100%	70%, 100% (Met)	NCID 70%; NCEH 100%	70%, 100% (Met)	NCID 70%	NCID 70%	N/A
15.1.3	Relationship of work orders (scheduled and unscheduled maintenance).	N/A	95%, 5% (Met)	Scheduled 95%; Unscheduled 5%	95%, 5% (Met)	Scheduled 95%; Unscheduled 5%	95%, 5% (Met)	Scheduled 95%; Unscheduled 5%	Scheduled 95%; Unscheduled 5%	N/A

[1] Project approved by the HHS Capital Investment Review Board to proceed with only analyses needed to support project. The project has not been approved for execution and funding beyond the analysis portion. CDC is continuing with the analyses as approved.

Long Term Objective 15.1, Performance Measure 1:

The aggregate scoring of four vital components (scope, schedule, cost and quality) of capital construction will most accurately assess successful performance and use of appropriated funds. The four combined components provide a comprehensive snapshot of capital construction. Scope, schedule, cost and quality are identified and approved consistent with the Facilities Project Approval Agreement process. The scope component will identify the predefined project needs; the schedule component will reflect the critical milestone dates; the cost component will establish the approved project budget; and the quality component will incorporate the scoring reflecting the use of appropriate building standards and codes. Since FY 2005, CDC has consistently met its goal of having greater than or equal to 90 percent of capital projects meet their scope, schedule, budget, and quality targets.

This goal is ambitious because in most years in order to meet the goal, the program cannot allow more than one project to not meet its target.

Long Term Objective 15.1, Performance Measure 2:

The movement of CDC laboratorians into CDC standard space will facilitate CDC's ability to meet its scientific mission. CDC standard space includes standards for bio-safety, CDC design, space planning, and accreditation of laboratory animal care and HHS utilization rate policy. This metric has underlying assumptions concerning the stability of CDC's growth rates, workforce composition, laboratory standards, and applicable codes. Any significant changes in baseline assumptions would require appropriate upward/downward adjustments to target rates.

By moving select components of the Infectious Diseases program into Building 18, the Emerging Infectious Disease Laboratory, CDC met its goal of 70 percent occupancy for Infectious Diseases for FY 2007.

This building houses the Division of Bacterial and Mycotic Diseases (DBMD), the Division of Viral and Rickettsial Diseases (DBMD), the Division of HIV/AIDS Prevention (DHAP), HIV and Retrovirology Branch, and the Division of Viral Hepatitis (DVH). Building 18 contains unique high containment laboratory space to support research on hazardous pathogens such as Ebola, Avian Flu, and SARS. The facility is also the central receiving, processing and response lab for the CDC Bioterrorism Preparedness and Response Program and Rapid Response/Advanced Technology Lab.

With the occupancy of Building 110, the Environmental Toxicology Laboratory, CDC met 100 percent of its FY 2005 goal to move the National Center for Environmental Health (NCEH) into CDC standard space. This facility houses the Division of Laboratory Sciences (DLS) whose employees use advanced laboratory science and innovative techniques to prevent disease from exposure to toxic chemicals in the environment; respond to terrorism and public health emergencies involving chemicals; and improve laboratory methods to diagnose and prevent disease. Scientists are working on developing a breakthrough test for botulinum and other toxins. The Radionuclide Laboratory measures select radionuclides that might result from "dirty bombs" or other releases. CDC's award-winning Newborn Screening Quality Assurance Program is the only source in the world for ensuring the accuracy of newborn screening tests responsible for identifying thousands of babies each year who are born with genetic or metabolic disorders. In addition, Building 110 serves as the home of the world reference laboratory for measuring cholesterol, triglycerides, and high and low-density lipoproteins.

This performance measure is directly impacted by the delivery of capital lab building projects on schedule. CDC has met this target since FY 2005, however the ability to meet this target in the future depends on the completion of Building 23.

Long Term Objective 15.1, Performance Measure 3:

This measure will track the percentage of maintenance projects that are scheduled (i.e., planned) to maintain the facilities, versus the percentage of unscheduled work orders tied to repairs of non-functioning or faulty systems. In general, all facilities are better protected through scheduled maintenance. Five percent is a minimal amount of unscheduled maintenance/repair projects needed to maintain its billions of dollars of facilities, yet CDC has consistently met this goal since FY 2005 and should continue to do so in the future.

TERRORISM PREPAREDNESS AND EMERGENCY RESPONSE

UPGRADING STATE AND LOCAL CAPACITY

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Efficiency Long Term Objective 16: Create program efficiencies that improve services and conserve resources for mission-critical activities.										
16.E.1	Decrease the amount of time it takes the Division of State and Local Readiness (DSLR) Project Development Officers to conduct technical reviews of work plans and budgets for all 62 grantees by providing appropriate tools and functionality in the DSLR Management Information System (MIS).	N/A	N/A	Baseline	30 days	28 days	12/2008	25 days	21 days	N/A

Efficiency Measure 16.E.1:

CDC's DSLR is responsible for providing management oversight and technical assistance for the administration of the Public Health Emergency Preparedness (PHEP) Cooperative Agreement. As part of the application process, grantees are required to submit detailed work plans and budgets which can total 100 pages each. CDC Project Development Officers (PDO) review, provide feedback, and approve applications before funds can be awarded. In addition, at the end of the extensive review process, PDOs provide recommendations for each work plan activity and line items are restricted or disallowed for the budget. The issues cited during this review are monitored and resolved during the year.

Historically, PDOs conducted technical reviews of the grants using paper-based approaches. This resulted in cumbersome paperwork and difficulty in tracking resolution of issues raised during the review process. To deal with these operational limitations, CDC's Management Information System (MIS) was enhanced to centralize the collection, tracking and management of review information. MIS not only maximizes efficiency of the initial application review, but helps facilitate technical assistance efforts throughout the course of the year. The automation and integration of this process will create overall efficiencies in the grants management process by decreasing the time it takes to conduct initial reviews and by providing rapid access to information to track and manage over time.

The efficiency gained from the integration of the review section into the MIS translates into other efficiencies from the grantees' standpoint including a reduction in the time it takes grantees to obtain feedback regarding their work plans and budgets from Project Officers. This in turn results in a faster implementation of recommended changes thereby improving the overall efficiency of their programmatic operations.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Preparedness Long Term Objective 16.3: Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food, or environmental samples that cause threats to the public's health.										
16.3.1	Percentage of states that have level three chemical lab capacity, and have agreements with and access to (specimens arriving within 8 hours) a level-one chemical lab equipped to detect exposure to nerve agents, mycotoxins, and select industrial toxins.[1]	N/A	50% (Exceeded)	100%	100% (Met)	100%	100% (Met)	100%	100%	N/A
16.3.6	Percentage of state public health laboratories that directly receive CDC PHEP funding that can correctly subtype E.Coli O157:H7 and submit the results into a national reporting system within four working days for 90% of the samples received.	N/A	N/A	N/A	N/A	Establish Baseline	3/2008	TBD	TBD	N/A

[1]Please note that the nomenclature has changed for chemical laboratories: level-three labs are now referred to as level-one labs and level-one labs are referred to as level-three labs.

Long Term Objective 16.3, Performance Measure 1:

Level-three laboratories, also called sentinel laboratories, rule out the presence of agents and refer samples to reference labs through the use of specified protocols. As a public health preparedness standard, each state should have the capacity to conduct, rule-out and transfer activities. CDC is training all 62 level-three public health chemical laboratories (i.e., chemical terrorism coordinators in these laboratories) in the proper collection and shipment of human samples following a chemical terrorism event. This training also includes an overview of chemical agents; CDC's responsibilities in responding to chemical terrorism events; a discussion of federal regulations on diagnostic packaging procedures and evidentiary-control measures; and hands-on exercises involving the packaging and shipping of human samples. These public health chemical laboratories will then train internal partners (e.g., hospital laboratories, HAZMAT, doctors, office laboratories) in the proper collection and shipment of human samples after a chemical-terrorism event.

In FY 2006, significant progress was made on this measure as 100 percent of states have level-three lab capacity. This progress was maintained in FY 2007. Fifty percent of the states are within an eight hour driving distance to a level-one chemical laboratory due to CDC's efforts in increasing the number of level-one laboratories from five to ten in FY 2005.

Long Term Objective 16.3, Performance Measure 6:

This measure was recently approved by OMB to replace a previous DSLR PART measure. The original measure (Percentage of state and local public health agencies will be in compliance with CDC recommendations for using standards-based, electronic disease surveillance systems for appropriate routine public health information collection, analysis and reporting appropriate public health authorities.) lacked specificity regarding what constitutes "compliance" and was problematic from the standpoint that grantees do not have complete control over whether local public health agencies comply.

This measure reflects laboratory accuracy and timeliness, as public health agencies must be able to inform local, state, and national laboratorians and epidemiologists of disease occurrences in a timely manner in order to determine the extent and scope of potential outbreaks and to minimize the effects of these outbreaks. A baseline will be established in March 2008, and targets will be set thereafter.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Preparedness Long Term Objective 16.4: Improve the timeliness and accuracy of communications regarding threats to the public's health.										
16.4.1	Percentage of LRN labs that report routine public health testing results through standards-based electronic disease surveillance systems and have protocols for immediate reporting by telephone for Category A agents (bacillus anthracis, yersina pestis, francisella tularensis, clostridium botulinum toxin and variola major) for which they conduct testing. [O]	N/A	100% (Met)	100%	80% (Unmet)	100%	100% (Met)	100%	100%	N/A

CDC Preparedness Long Term Objective Four and its supporting measure corresponds with the *Public Health System Support* functional objective.

Long Term Objective 16.4, Performance Measure 1:

Currently, all Laboratory Response Network (LRN) labs can use established protocols for telephone reporting and, in addition, can use an interim spreadsheet mechanism for reporting through the secure website. LRN laboratories faced a variety of challenges associated with the deployment of the software solution, Results Messenger Version 2. Several issues delayed individual labs from installing the new software, including limited resources, labs lacking required hardware, and security issues associated with installing new hardware. Also, some labs have opted to forgo the installation of Results Messenger in favor of installing LIMS-compliant systems for reporting laboratory testing results to CDC.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 16.6: Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.										
16.6.1	Expand and enhance the Health Alert Networks (HAN) ability to rapidly provide access to public health guidelines, best practices, and information on the effectiveness of public health interventions. [O]	a – d Unmet	a) 57% of Cooperative Agreement recipients acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis (Unmet) b) 97% (Exceeded) c) 60% (Met) d) 98% (Exceeded)	a) 70% of state health departments acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis. b) 75% of state grantees will have a protocol for testing and documenting send/receive capabilities	a) 58% of Cooperative Agreement recipients acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis (Unmet) b) Unmet c) 60% (Met) d) 98% (Exceeded)	a) 75% of state health departments acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis b) 80% of state grantees will have a protocol for testing and documenting send/receive capabilities	a) 77% of State Health Departments acknowledging receipt of health alert messages within 30 minutes of delivery. (Exceeded) b) (Unmet)	a) 80% of state health departments acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis b) 85% of state grantees will have a protocol for testing and documenting send/receive capabilities	a) 85% of state health departments acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis b) 85% of state grantees will have a protocol for testing and documenting send/receive capabilities	N/A
16.6.2	Percentage of state public health agencies that are prepared to use materiel contained in the SNS as demonstrated by evaluation of standard functions as determined by CDC. [O]	72% (Exceeded)	76% (Exceeded)	80% prepared	70% (Unmet)	90% prepared	78% (Unmet)	90% prepared	90% prepared	N/A

CDC Preparedness Long Term Objective Six and its supporting measures correspond with the *Public Health System Support*, and the *Response and Recovery Operations* functional objective.

Long Term Objective 16.6, Performance Measure 1:

To obtain the status of performance for this measure, CDC's National Center for Public Health Informatics (NCPHI) conducted three different HAN response tests based on 50 grantees (HAN Coordinators) were conducted in FY 2007. Plans for coming years include continued technical assistance and network testing to ensure timely message translation, dissemination, local response, and feedback. Note that targets b) and d) were retired after data was reported for FY 2005 activities. The second portion of the target (part b) is listed as unmet given internal discussions regarding reporting methodology. CDC anticipates negotiations with HHS and OMB to retire this part of the measure.

Long Term Objective 16.6, Performance Measure 2:

CDC will continue working towards the achievement of 100 percent preparedness of state public health agencies regarding the use of materials contained in the SNS as demonstrated by evaluation of standard functions determined by CDC. In FY 2007, 78 percent representing 42 out of 54 project areas were performing within the acceptable range. Preparedness to receive, stage, store and distribute SNS materiel is essential to saving lives at risk during a public health emergency. CDC will continue to evaluate the preparedness of state public health agencies through exercises and reviews of Strategic National Stockpile (SNS) distribution plans.

Although there are many challenges to sustaining this preparedness capability, CDC believes that recent efforts to enhance preparedness through more rigorous planning and assessment processes combined with technical assistance, training and exercises will improve grantees long term ability to perform during a public health emergency.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Preparedness Long Term Objective 16.9: Decrease the time needed to implement recommendation from after-action reports following threats to the public's health.										
16.9.1	Percentage of public health agencies that directly receive CDC PHEP funding that can convene within 60 minutes of notification a team of trained staff that can make decisions about appropriate response and interaction with partners.	N/A	N/A	N/A	N/A	Establish Baseline	3/2008	TBD	TBD	N/A
16.9.5	Percentage of public health agencies that directly receive CDC PHEP funding that, at least once/year, re-test a response following completion of corrective action(s) identified in a prior actual or simulated response.	N/A	N/A	N/A	N/A	Establish Baseline	3/2008	TBD	TBD	N/A

CDC Preparedness Long Term Objective Nine and its supporting measure correspond with the *Public Health System Support* and the *Program Operations* functional objective.

Long Term Objective 16.9, Performance Measure 1:

This measure was recently approved by OMB to replace a previous DSLR PART measure. The original measure *(Properly equipped public health emergency response teams will be onsite within four hours of notification by local public health officials, to assess the public health impact and determine the appropriate public health intervention in response to Category A agents.)*

assumed that teams belong to the state public health agency. In making this assumption, the measure addresses a somewhat narrow capability in terms of public health emergency preparedness. Additionally, the measure assumes a uniform protocol across all grantees for state and local public health agency interaction. However, some states provide all local public health services, while other state agencies operate strictly in support of local response. The measure does not allow for local variations in response to Category A agents. Instead, it implies that the state will respond whether requested or not.

This new measure more accurately stipulates public health agencies must be able to rapidly convene staff to integrate information and prioritize resource allocation to ensure timely and effective coordination within the public health agency and with key response partners during an emergency response. A baseline will be established in March 2008, and targets will be set thereafter.

Long Term Objective 16.9, Performance Measure 5:

This measure was recently approved by OMB to replace a previous DSLR PART measure. The original measure *(Percentage of state public health agencies improve their capacity to respond to exposure to chemicals or category A agents by annually exercising scalable plans and implementing corrective action plans to minimize any gaps identified.)* focused on chemicals or category A agents, which did not provide an all-hazards assessment of public health emergency preparedness. In addition, the original measure did not provide enough specificity with regard to the activities being measured. Exercising and implementing corrective action plans are two interconnected processes, but they are not always completed in a seamless, linear manner, and the criteria to determine if the activities in the measure have been successfully completed were not clear.

The new measure reflects the important ability of public health agencies to systematically re-test their response capabilities in order to provide evidence that planned and implemented corrective actions have been effective in improving response capacity. A baseline will be established in March 2008, and targets will be set thereafter.

UPGRADING CDC CAPACITY

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Efficiency Long Term Objective 16: Create program efficiencies that improve services and conserve resources for mission-critical activities.										
16. E.3	Decrease annual costs for personnel and materials development with the development and continuous improvement to the budget and performance integration information system tools. [E]	$125,000/ Excel system (Baseline)	$101,000/ Budget and Performance Integration (BPI) system	N/A	$86,800/BPI and Health Impact system	$50,000/ BPI and Health Impact system	$8,685.20/BPI and Health Impact system (Met)	$0/BPI and Health Impact system	$0/BPI and Health Impact system	N/A

Efficiency Measure 16.E.3:

This is an OMB approved efficiency measure for both the Upgrading CDC Capacity and Biosurveillance programs. COTPER utilizes a team of contractors to help facilitate their Health Impact Planning (HIP) process each year. This team also provides supplemental support in regards to this measure. Since CDC's budget and performance toll is still in its early stages of its life span, the system is not able to provide functionality with performance reporting and report generation. The contractor team has created a webform that the projects use to report on performance three times a year. The team also maintains an access database that houses the same information, but is able to provide more robust report generation and analysis. The team logs hours spent on these activities. The intent of the measure is to reach a point where CDC's budget and performance integration tool provides all of these services managed by internal FTEs, therefore reducing costs for COTPER. Therefore, as systems continue to improve, the goal is to gradually decrease the time and material costs while not impacting the quality and timeliness of work developed and delivered.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Preparedness Long Term Objective 16.3: Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food, or environmental samples that cause threats to the public's health.										
16. 3.2	Percentage of Laboratory Response Network (LRN) labs that pass proficiency testing for Category A and B threat agents.	N/A	83% (Exceeded)	80%	87% (Exceeded)	100%	91% (Unmet)	90%	90%	N/A
16. 3.5	By 2010, CDC's laboratory system will decrease the time from receipt of tissue, food and environmental samples to confirm and report chemical, biological and radiological agents to stakeholders. [O]	Targets Under Development								

Long Term Objective 16.3, Performance Measure 2:

This measure determines the readiness posture of the LRN for rapid detection of biological threat agents. Since laboratories infrequently encounter biological threat agents, the proficiency testing (PT) program provides familiarity in working with these agents, performing LRN assays using agent-specific testing algorithms, and using available electronic resources to report test results.

The PT program has been in place since the LRN was founded in FY 1999. At its onset, very few LRN member laboratories were able to rapidly and accurately identify biological threat agents and other agents of public health importance. Due to testing challenges and the need for increased training, the FY 2003 baseline passing rate was approximately 75 percent. By the end of FY 2005, the passing rate rose to 83 percent and at the end of FY 2006 the passing rate increased yet again to 87 percent. The passing rate again increased in FY 2007 to 91 percent, although the FY 2007 target of 100 percent was not met. A 100 percent passing rate is not feasible for several reasons, including an evolving priority threat list which results in the introduction of tests for new agents and the release of new technologies and equipment which require additional training and experience to master. Additionally, the LRN program office at CDC is working to increase the complexity of the PT program to include multiple agents in a single challenge, testing in various non-clinical samples (e.g., food, water, and environmental samples), and requirements to complete a full testing algorithm rather than solely focusing on rapid tests. The combination of new tests, new technologies, and the increasing complexity of the PT program suggests that a 100 percent passing rate is unachievable. Laboratories that fail a proficiency test are required to go through remediation steps that may include consultation, successful completion of a follow-up proficiency test, and/or hands-on training. Therefore, FY 2008 and FY 2009 targets have been adjusted accordingly, yet remain ambitious.

Long Term Objective 16.3, Performance Measure 5:

The time reductions stipulated by this performance measure will directly affect the ability of public health and emergency response entities to identify events of national public health importance. Indirectly this measure will decrease the time needed to communicate with the public about important health issues, initiate investigations, and to identify and provide countermeasures.

Methods of incorporating individual project-level data reflecting current laboratory activities will contribute to the overarching implications of this Upgrading CDC Capacity performance measure. With further advancements of CDC goal action planning, appropriate project alignment and contribution to finalizing target completion will occur by second quarter FY 2008.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Preparedness Long Term Objective 16.5: Decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health.										
16.5.3	By 2010, CDC's epidemiology system will reduce the time to initiate, coordinate and resolve investigations to identify causes, risk factors and recommended interventions. [O]	Targets Under Development								

CDC Preparedness Long Term Objective Five and its supporting measure correspond with the *Response and Recovery Operations*, and the *Epidemiology and Non-Bench Research* functional objectives.

Long Term Objective 16.5, Performance Measure 3:

The time reductions stipulated by this performance measure will directly affect the ability of public health and law enforcement personnel to implement prevention interventions, decrease the time to classify health issues as terrorism or naturally occurring, and decrease the time to identify risk factors and causes of urgent public health events. These time savings will decrease the time needed to communicate with the public about important health issues, and to identify and provide countermeasures.

Methods of incorporating individual project-level data reflecting current epidemiologic and non bench research activities will contribute to the overarching implications of this Upgrading CDC Capacity performance measure. With further advancements of CDC goal action planning, appropriate project alignment and contribution to finalizing target completion by second quarter FY 2008.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 16.6: Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.										
16.6.7	By 2010, CDC's response operations system will decrease the time from event to actions that will minimize morbidity and mortality. [O]	Targets Under Development								

CDC Preparedness Long Term Objective Six and its supporting measure correspond with the *Public Health System Support*, and the *Response and Recovery Operations* functional objective.

Long Term Objective 16.6, Performance Measure 7:

The time reductions stipulated by this performance measure will directly affect the ability of public health and law enforcement personnel to identify events of national public health importance, initiate investigations, determine causes and risk factors, identify and implement effective countermeasures, and provide timely and accurate communications with the public.

Methods of incorporating individual project-level data reflecting current response and control activities will contribute to the overarching implications of this Upgrading CDC Capacity

performance measure. With further advancements of CDC goal action planning, appropriate project alignment and contribution to finalizing, target completion by second quarter FY 2008.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Preparedness Long Term Objective 16.9: Decrease the time needed to implement recommendation from after-action reports following threats to the public's health.										
16.9.2	Increase the percentage of the TPER allocation for which budget execution matches strategic funding priorities.	Targets Under Development								
16.9.3	Improve the on-time achievement of individual project milestones for Epidemiology, Laboratories and Emergency Response.	N/A	N/A	Baseline	87%	90%	84% (Unmet)	93%	95%	N/A
16.9.4	Achieve progressive improvements in the quality of projects submitted for TPER Upgrading CDC Capacity funding consideration.	N/A	N/A	N/A	N/A	Baseline	74%	78%	85%	N/A

CDC Preparedness Long Term Objective Nine and its supporting measures correspond with the *Public Health System Support* and the *Program Operations* functional objective.

Long Term Objective 16.9, Performance Measure 2:

This measure reflects the need to ensure that budget execution matches strategic funding priorities. CDC is developing a decision-support process for linking budget formulation to the priorities identified in the CDC's Preparedness Goal Action Plan. This decision-support process will allow consideration of new initiatives, expansion or enhancement to existing projects, or the elimination of completed or out-dated projects. Strategies to determine the variance of budget formulation from goals priorities is underway. Additionally, project selection resulting from Spend Plan FY 2007 decisions will contribute to this process for target completion by second quarter FY 2008.

Long Term Objective 16.9, Performance Measure 3:

All individual projects funded to Upgrade CDC Capacity must improve performance in order to achieve the long term measures. Individual project performance is monitored continuously and can be summarized as the average time-appropriate achievement of milestones in the core functional areas. Improving on-time achievement of individual milestones for Epidemiology, Laboratory and Emergency Response functional objective related projects ensures that the projects are making substantial progress to complete all planned activities by the end of FY 2007 in order to help achieve CDC's Health Protection Goals. The target was not achieved due to a number of projects extending the completion of their milestones into the next fiscal year. This extension is due to a number of reasons depending on the specific project's situation. For example, a project's priorities might change during the fiscal year so work specific to a milestone can get extended past the initial completion date while efforts are spent on other activities.

Long Term Objective 16.9, Performance Measure 4:

The spend plan process maximizes efficiency by centralizing the project submission and review process, allowing for the early identification of duplicative efforts. Project submissions include detailed workplans and timelines. Submissions must also include responses to standardized evaluation questions that are used to rate and select projects for funding. This process allows for the selection of projects that are most likely to achieve the objectives of upgrading some part of CDC's preparedness capacity, are not duplicative of each other, are well-specified and likely to succeed, thus improving overall preparedness capacity.

BIOSURVEILLANCE

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Preparedness Long Term Objective 16.2: Decrease the time needed to classify health events as terrorism or naturally occurring in partnership with other agencies.										
16.2.1	Number of top 50 metropolitan areas using BioSense.	N/A	10 (Baseline)	40	38 (Unmet)	50	49 (Unmet)	50	Additional population coverage in Top 50 metropolitan areas	N/A
16.2.2	By 2010, the BioSense program will reduce the time needed from a triggering biosurveillance event (the identification of a potential disease event or public health emergency event) to initiate event-specific standard operating procedures (the initiation of a public health investigation and, if needed, subsequent public health intervention) for all infectious, occupational or environmental (whether man-made or naturally occurring) threats of national importance. [O]	Targets Under Development								

CDC Preparedness Long Term Objective Two corresponds with the *Public Health Systems Support* and the *Health Monitoring and Surveillance* functional objectives.

Long Term Objective 16.2, Performance Measure 1:

BioSense program officials have determined that by 2010, all levels of public health with jurisdiction over the top 50 U.S. metropolitan areas will use BioSense for biosurveillance and local health situational awareness as needed by accessing timely (less than 24 hours old) healthcare data from a statistically representative population.

These ambitious steps require continuous program improvement, establishment of new partnerships and data sharing agreements, information technology improvements, and realization of efficiencies. They also reflect the commitment of CDC to the President's national priorities in coordination with the Office of the National Coordinator for Health Information Technology and the American Health Information Community (AHIC). The program's FY 2005 baseline and FY 2006 data for this output measure reflect its early progress toward this goal. Once the top 50 metropolitan areas are covered, the focus will be on greater hospital coverage in those same cities rather than additional geographies. In 2007, BioSense had data from 25 of the top 50 Metropolitan Statistical Areas (MSAs). The top 50 MSAs were identified through the use of the census bureau website.

BioSense acquired real-time clinical care data from over 350 healthcare sources and receives data from 466 DOD and 863 VA healthcare facilities. Currently, these data sources cover 49 of the top 50 metropolitan areas, all of the BioWatch cities and all but five of the CRI cities (67 out

of 72). There are approximately 800 users and 124 state and local public health jurisdictions with access to BioSense.

This Performance Measure corresponds to the Health Monitoring and Surveillance functional objective.

Long Term Objective 16.2, Performance Measure 2:

The time reductions stipulated by this performance measure will directly affect the ability of public health and law enforcement personnel to decrease the time to classify health issues as terrorism or naturally occurring, to decrease the time needed to detect aberrations. Indirectly, these time savings will decrease the time needed to communicate with the public about important health issues, and to identify and provide countermeasures.

BioSense data reflecting advancements in information technology infrastructure, workforce recruitment and training, and development of comprehensive and tested standard operating procedures will contribute to this biosurveillance performance measure. With further advancements in rapid identification of trends in clinical data, targets will be completed by 2nd quarter FY 2008.

This Performance Measure corresponds to the Public Health System Support functional objectives.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Preparedness Long Term Objective 16.3: Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food, or environmental samples that cause threats to the public's health.										
16.3.3	Number of Laboratory Response Network member laboratories able to use the current Laboratory Information Management System (LIMS) for electronic data exchange.	N/A	N/A	Baseline	5	15	10 (Unmet)	30	50	N/A
16.3.4	By 2010, the Laboratory Response Network Results Messenger will reduce the time needed from a triggering biosurveillance event (i.e., transmission of data regarding the identification of any Category A or B agent) to initiate event-specific standard operating procedures (e.g., aggregation of data at a national level) for all infectious, occupational or environmental (whether man-made or naturally occurring) threats of national importance. [O]	Targets Under Development								

Long Term Objective 16.3, Performance Measure 3:

The LIMS Integration Team is dedicated to producing tools to help laboratories enable standard electronic exchange of LRN data using their own laboratory information management systems. Achieving the long term objective for the LRN Results Messenger reflects the need to develop, maintain, and expand information technology solutions for rapid exchange of laboratory results to continuously reduce the amount of time required for critical results to be identified and reported. This requires continuous program improvement, establishment of new partnerships and data sharing agreements, information technology improvements, and realization of efficiencies.

The targets for this measure are primarily dependent on the technical capability and resources of the LRN Member labs. The realistic constraints of public health partners being able to use their own systems to meet PHIN requirements is one of the key drivers of providing a software solution, LRN Results Messenger, to the LRN labs. Therefore, while labs are progressing toward LRN LIMS Integration, they are still able to exchange LRN lab data according to PHIN requirements and are able to fully participate in LRN activities.

Long Term Objective 16.3, Performance Measure 4:

The time reductions stipulated by this performance measure will directly affect the ability of public health and the emergency response entities to decrease the time to classify health issues as terrorism or naturally occurring, as well as to decrease the time needed to detect aberrations. Indirectly, these time savings will decrease the time needed to communicate with the public about important health issues and to identify and provide countermeasures.

Laboratory Response Network Results Messenger data reflecting advancements in information technology infrastructure, workforce recruitment and training, and development of comprehensive and tested standard operating procedures will contribute to this biosurveillance performance measure. With further advancements in rapid identification of trends in terrorism-related laboratory data, targets will be completed by second quarter FY 2008.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Preparedness Long Term Objective 16.5: Decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health.										
16.5.1	Number of quarantine stations that are fully staffed with public health professionals who are prepared to respond appropriately when needed.	N/A	10 (Baseline)	20	18 (Unmet)	Up to 25	20 (Met)	Up to 25	Up to 25	N/A
16.5.2	By 2010, the Quarantine Stations will reduce the time needed from a triggering biosurveillance event (notification of an international or interstate traveler who traveled while infectious with a quarantinable disease or other infectious disease of public health importance) to initiate event-specific standard operating procedures (e.g., isolation, quarantine, contact	Targets Under Development								

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Preparedness Long Term Objective 16.5: Decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health.										
	notification) for all infectious, occupational or environmental (whether man-made or naturally occurring) threats of national importance. [O]									

CDC Preparedness Long Term Objective Five and its supporting measures correspond with the *Response and Recovery Operations*, and the *Epidemiology and Non-Bench Research* functional objectives.

Long Term Objective 16.5, Performance Measure 1:

Expanding and maintaining the Quarantine and Migration Health System is necessary to protect the U.S. from international communicable disease threats, both natural and intentional. Quarantine Station expansion and enhancement will improve the systematic collection, analysis, interpretation, and dissemination of data related to public health events at U.S. ports of entry. An expanded and enhanced quarantine system includes not only increasing CDC's physical presence at U.S. ports of entry, but also fully staffing each station with a multidisciplinary team of quarantine medical officers, public health advisors, epidemiologists, and information technicians, enhancing the stations' links to a global network for international traveler disease surveillance, increasing preparedness and response at U.S. ports of entry, and expanding collaboration and partnership activities with state and local agencies.

Long Term Objective 16.5, Performance Measure 2:

The time reductions stipulated by this performance measure will directly affect the ability of public health and law enforcement personnel to decrease the time to classify health issues as terrorism or naturally occurring, to decrease the time needed to detect aberrations. Indirectly, these time savings will decrease the time needed to communicate with the public about important health issues, and to identify and provide countermeasures.

Program data reflecting advancements in information technology infrastructure, workforce recruitment and training, and development of comprehensive and tested standard operating procedures will contribute to this biosurveillance performance measure. With further advancements in prevention and introduction of infectious disease from foreign countries, targets will be completed by second quarter FY 2008.

STRATEGIC NATIONAL STOCKPILE

The Division of the Strategic National Stockpile (DSNS) went through the PART process in FY 2005 with targets set out only as far as FY 2008. Since that time, DSNS has undergone internal strategic planning processes at the CDC Coordinating Center level and a cascaded planning process at the program level. These strategic planning processes have complimented the ongoing CDC Goals Action Planning. Also since the completion of the PART, the PAHPA legislation provides guidance for the development of medical countermeasure acquisition targets that will impact the SNS.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Efficiency Long Term Objective: Create program efficiencies that improve services and conserve resources for mission-critical activities.										
16.E.2	Dollars saved per $1 invested in the Food and Drug Administration's (FDA) Shelf Life Extension Program (SLEP) for available projects. [E]	N/A	$22 (Baseline)	$24	$20 (Unmet)	$26	$13 (Unmet)	$28	$28	N/A

Efficiency Measure 16.E.2:

CDC will continue to partner with the U.S. Food and Drug Administration on the Shelf Life Extension Program (SLEP). The return on investment (ROI) calculation for SNS participation in SLEP is based on each $1 spent on SLEP costs (e.g., testing, shipping, re-labeling). For FY 2007, ROI was $13 for each $1 spent on SLEP costs. Cost avoidance projections do not reflect fluctuations in product handling costs or the actual amount of product eligible for FDA SLEP program. In order to capture the true efficiency gained by participating in the program, the focus should be on the actual ROI. CDC will continue to pursue cost avoidance savings in association with participation in the SLEP program in FY 2009. It is important to note that the PART performance targets reflect incremental progress required by the PART analysis and reporting process and may not accurately capture the true efficiency gained by participating in the FDA SLEP program. For example, cost avoidance estimates for FY 2007 are expected to be much higher than actual targets due to the volume of stockpiled products eligible, while the actual number of products in FY 2006 was much less. Actual cost avoidance projections are also affected by fluctuation in handling costs.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 16.6: Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.										
16.6.3	Number of treatments/prophylaxis for the appropriate response to known terrorist threats or public health emergencies for chemical, biological, radiological and nuclear threats in millions. [O]	N/A	N/A	N/A	N/A	N/A	N/A	2.3, 60, 0.17	TBD per BARDA	N/A
16.6.4	The number of successful annual exercises that test response to multiple events with a 12-hour response time. [O]	N/A	1 (Baseline)	1	1 (Met)	1	1 (Met)	1	1	N/A

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long Term Objective 16.6: Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.										
16.6.5	Number of trained and ready Technical Advisory Response Units (TARU) for response to multiple events.	N/A	5 (Baseline)	6	6 (Met)	7	6 (Unmet)	9	7	N/A
16.6.6	Percentage of inventory discrepancies that are reduced by using quality inventory management systems. [O]	N/A	6 % (Baseline)	<5%	0.33% (Exceeded)	<5%	24.33% (Unmet)	<5%	<5%	N/A

CDC Preparedness Long Term Objective Six and its supporting measures correspond with the *Public Health System Support*, and the *Response and Recovery Operations* functional objective.

Long Term Objective 16.6, Performance Measure 3:

The DSNS went through the PART process in CY 2005. Since that time, DSNS has undergone internal strategic planning processes first at the CDC Coordinating Center level and then a cascaded planning process at the program level. These strategic planning processes have complimented the ongoing internal CDC Goals Action Planning. Also since the completion of the PART, the PAHPA legislation provides guidance for the development of medical countermeasure acquisition targets that will impact the SNS. Measure 3 will be particularly impacted as acquisition targets are reassessed and set by the newly formed Biomedical Advanced Research and Development Authority (BARDA). Based on the establishment and pending implementation of this legislation, the DSNS looks forward to negotiating changes to these measures with HHS and OMB as necessary.

Long Term Objective 16.6, Performance Measure 4:

CDC conducted a full scale exercise at the end of FY 2007 to test its response operations and validate the ability to respond to multiple public health emergencies in a timely manner.

Long Term Objective 16.6, Performance Measure 5:

As a result of the PART process, DSNS developed new performance measures. In FY 2006, CDC met its goal of six trained and ready TARU for response to multiple events. At this time, TARU capacity remains at the target level of six technical teams. The added mission of deploying Federal Medical Stations (FMS) when needed with CDC personnel will have an impact on the program's future ability to increase the number TARUs. Thus, CDC has reduced its TARU target from nine in FY 2008 to seven in FY 2009. In light of these competing resources, CDC will evaluate its capacity to sustain current emergency response systems and meet growth targets.

Long Term Objective 16.6, Performance Measure 6:

As a result of the PART and SNS planning process, CDC developed performance measures to track inventory discrepancies. The discrepancy percentage represents the total number of instances where the locations for items identified for that quarter's inventory do not exactly match with the inventory report for that item. In FY 2006, inventory discrepancies were reduced to 0.33 percent, exceeding the target of less than five percent. In FY 2007, discrepancies were at the rate of 24.33 percent. This large discrepancy rate was caused by a single clerical error and no SNS items were lost as a result of that error. The average for the first three quarters of the fiscal year was 3.67 percent meeting the target of less than five percent.

OVERVIEW OF PERFORMANCE

DISCUSSION OF CDC STRATEGIC PLAN

Health Protection Goals & Objectives

CDC has refocused its efforts, reflected in its Health Protection Goals, to accelerate health impact, reduce health disparities, and protect people from current and imminent health threats. These goals are organized in four thematic areas:

- **Healthy People in Every Stage of Life** – CDC is customizing science and programs in the areas where it can accelerate health impact by focusing on Americans' health protection needs during each stage of life. Recognizing that many health problems that occur in adulthood can be prevented by mitigating risk factors early in life, the life stage goals take an early and lifelong approach to prevention. By using the unique routes by which people at various stages of life receive health information most effectively, CDC will improve its ability to develop targeted prevention-oriented health solutions.
- **Healthy People in Healthy Places** – CDC is exploring the potential for accelerating health impact by improving the quality and safety of the places where Americans live, work, learn, and play. By bringing CDC science and programs together to focus on these environments, we will ensure that we are doing everything we can to improve the lives and health of Americans.
- **People Prepared for Emerging Health Threats** – CDC has shifted the strategic focus of its preparedness investments from building infrastructure to improving the speed at which the agency and its partners respond to public health emergencies. Our preparedness goals are designed to directly measure how quickly we prevent, detect, investigate, and control public health emergencies resulting from natural disasters, terrorism, infectious disease, and occupational and environmental threats. CDC is using scenario analysis to identify key factors for improving response time. The first scenarios to be addressed include influenza, anthrax, plague, emerging infections, and toxic chemical and radiation exposure.
- **Healthy People in a Healthy World** – The pace at which global threats are emerging is accelerating with increasing international travel and the interconnectivity of national economies. Recognizing the growing health, economic, and political consequences of global health threats, CDC is working with American and international partners to dramatically increase the scale and effectiveness of its efforts to protect Americans at home and abroad and to promote health globally.

Working Strategically to Accelerate Health Impact

CDC is now a more integrated, adaptable, and responsive agency. Six strategic imperatives have been identified to support the effective implementation of our goals and 98 percent of the agency's budget is aligned with agency goals and strategic imperatives. CDC is currently developing goal action plans to link, leverage, and coordinate CDC's ongoing activities and further align resources with priorities. Coordinating Centers and Offices are structured to improve internal and external coordination and leveraging of resources to achieve these priorities. CDC's National Centers conduct and support the highest quality science that drives the agency's work. As always, CDC's program Divisions and National Centers will be responsible for planning and implementing activities and projects, overseeing their quality, and measuring their results. The agency's goal action planning and implementation cycle is aligned with the federal budget cycle and CDC will continue to be guided by Administration and

Congressional intent to ensure that categorical disease dollars target the appropriate activities. However, the timing of the goals action planning will allow CDC to gather input from partners, stakeholders, advisory committees, and the public before the annual budget cycle begins. Over time, CDC's Health Protection Goals will allow CDC to objectively measure and demonstrate the impact of our health protection activities and will inform the public, the Administration, partners, and stakeholders about the state of the public's health.

Supporting HHS Strategic Goals and Objectives

As an operating division of HHS, CDC makes significant contributions to the development and advancement of the *HHS Strategic Plan 2007–2012*. As our Health Protection Goals continue to develop, they will continue to be informed by the strategic goals and objectives of the Department and the Secretary's Priorities.

CDC's Health Protection Goals strategically align with and directly support the four HHS Strategic Goal areas. Each of our overarching Health Protection Goals and their respective objectives support:

- Preventing the spread of infectious diseases (HHS Strategic Objective 2.1);
- Protecting the public against injuries and environmental threats (HHS Strategic Objective 2.2);
- Addressing the needs, strengths, and abilities of vulnerable populations (HHS Strategic Objective 3.4);
- Conducting and overseeing applied research to improve health and well-being (HHS Strategic Objective 4.3); and,
- Communicating and transferring research results into clinical, public health, and human service practice (HHS Strategic Objective 4.4).

In addition, the overarching Healthy People in Every Stage of Life goals directly support:

- Increasing health care availability and accessibility (HHS Strategic Objective 1.2);
- Promoting and encouraging preventive health care, including mental health, lifelong healthy behaviors, and recovery (HHS Strategic Objective 2.3);
- Promoting the economic independence and social well-being of individuals and families across their lifespan (HHS Strategic Objective 3.1); and,
- Protecting the safety and fostering the well-being of children and youth (HHS Strategic Objective 3.2).

The overarching Healthy People in Healthy Places goals directly support:

- Improving health care quality, safety, cost, and value (HHS Strategic Objective 1.3);
- Protecting the safety and fostering the well-being of children and youth (HHS Strategic Objective 3.2); and,
- Encouraging the development of strong, healthy, and supportive communities (HHS Strategic Objective 3.3).

The overarching People Prepared for Emerging Health Threats goals and Healthy People in a Healthy World goals directly support preparing for and responding to natural and man-made disasters (HHS Strategic Objective 2.4).

The overarching Healthy People in a Healthy World goals also expand CDC's existing life stages goals to promote health globally in support of HHS Strategic Objectives 1.2, 2.3, 3.1, and 3.2.

The Secretary's Priorities of prevention, pandemic preparedness, and emergency response are also directly supported by CDC's overarching Health Protection Goals. The following tables illustrate the strategic alignment between CDC's Health Protection Goals and HHS strategic goals and objectives.

Supporting Healthy People 2010 National Health Objectives

CDC fully supports *Healthy People 2010*, and CDC's Health Protection Goals are designed to make CDC and our partners stronger contributors to the success of *Healthy People 2010*. The overarching Healthy People in Every Stage of Life and Healthy People in Healthy Places goals directly support the goals and objectives for *Healthy People 2010*. Consequently, *Healthy People 2010* measures will be used to support many of the objectives within the CDC Health Protection Goals. The overarching People Prepared for Emerging Health Threats goals address crucial public health issues that are not priorities in *Healthy People 2010*. CDC is actively participating in HHS efforts to begin planning for *Healthy People 2020*. Through CDC's active participation in the planning for *Healthy People 2020* objectives and the integration of *Healthy People 2010* measures into our strategic Health Protection Goals Action Plans, CDC is strategically aligned with and responsive to the health objectives of the nation.

As CDC is an active participant and supporter of the HHS efforts in planning for *Healthy People 2020*, an effort has been made to align the CDC Health Protection strategic goals and objectives with the HHS goals. The CDC objectives for the four overarching goals—Healthy People in Every Stage of Life, Healthy People in Healthy Places, People Prepared for Emerging Health Threats, and Healthy People in a Healthy World—lead to several sample objectives that are in full support of both *Healthy People 2020* and the CDC Health Protection Goals. Sample objectives that are possible outcomes of this alignment are outlined in the tables below.

LINKS TO HHS AND CDC STRATEGIC PLANS

	CDC STRATEGIC GOALS			
	People	Places	Preparedness	Global Health
HHS STRATEGIC GOALS				
GOAL 1: Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long term care.	X	X	-	X
1.1 Broaden health insurance and long term care coverage.	-	-	-	-
1.2 Increase health care service availability and accessibility.	X	-	-	X
1.3 Improve health care quality, safety, cost and value.	-	X	-	-
1.4 Recruit, develop and retain a competent health care workforce.	-	-	-	-
GOAL 2: Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.	X	X	X	X
2.1 Prevent the spread of infectious diseases.	X	X	X	X
2.2 Protect the public against injuries and environmental threats.	X	X	X	X
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery.	X	-	-	X
2.4 Prepare for and respond to natural and man-made disasters.	-	-	X	X
GOAL 3: Promote the economic and social well-being of individuals, families and communities.	X	X	X	X
3.1 Promote the economic independence and social well-being of individuals and families across the lifespan.	X	-	-	X
3.2 Protect the safety and foster the well-being of children and youth.	X	X	-	X
3.3 Encourage the development of strong, healthy and supportive communities.	-	X	-	-
3.4 Address the needs, strengths and abilities of vulnerable populations.	X	X	X	X
GOAL 4: Advance scientific and biomedical research and development related to health and human services.	X	X	X	X
4.1 Strengthen the pool of qualified health and behavioral science researchers.	-	-	-	-
4.2 Increase basic scientific knowledge to improve human health and development.	-	-	-	-
4.3 Conduct and oversee applied research to improve health and well-being.	X	X	X	X
4.4 Communicate and transfer research results into clinical, public health and human service practice.	X	X	X	X

ADDITIONAL ITEMS

SUMMARY OF FULL COST

FY 2009 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF FULL COST (DOLLAR IN MILLIONS)				
Unique ID	**Performance by HHS Strategic Goals and Performance Area**	**FY 2007**	**FY 2008**	**FY 2009**
	HHS Strategic Goal 1			
	HHS Strategic Goal 1.3			
	INFECTIOUS DISEASES			
4	**Preparedness, Detection, and Control of Infectious Diseases**	**$19.5**	**$18.7**	**$15.2**
4.1	Goal 1	$1.4	$1.4	$1.1
4.1.1	*Measure 1*	$0.3	$0.3	$0.2
4.2	Goal 2	$18.1	$17.3	$14.1
4.2.1	*Measure 1*	$1.3	$1.2	$1.0
	ENVIRONMENTAL HEALTH AND INJURY			
10	**Environmental Health**	$8.0	$6.1	$5.3
10.1	Goal 1	$8.0	$6.1	$5.3
10.1.3	*Measure 3*	$8.0	$6.1	$5.3
	Sub-total	***$27.5***	***$24.9***	***$20.5***
	HHS Strategic Goal 2			
	HHS Strategic Goal 2.1			
	INFECTIOUS DISEASES			
1	**Immunization and Respiratory Diseases** [1]	**$3,335.1**	**$3,394.5**	**$3,453.9**
	Immunization Grant Program	*$3,260.9*	*$3,216.3*	*$3,283.7*
1.1	Goal 1[1]	$1,621.2	$1,588.5	$1,621.3
1.1.1	*Measure 1*	$97.3	$95.3	$97.3
1.1.2	*Measure 2*	$16.2	$7.9	$8.1
1.1.3	*Measure 3*	$16.2	$7.9	$8.1
1.2	Goal 2[1]	$1,621.2	$1,588.5	$1,621.3
1.2.1	*Measure 1*	$194.5	$238.3	$259.4
1.2.2	*Measure 2*	$16.2	$15.9	$16.2
1.3	Goal 3	$18.5	$39.2	$41.1
1.3.1	*Measure 1*	$0.3	$1.2	$1.2
1.3.2	*Measure 2*	$0.3	$1.2	$1.2
1.4	Goal 4	N/A	N/A	N/A
1.4.1	*Measure 1*	N/A	N/A	N/A
	Influenza	*$74.1*	*$178.3*	*$170.1*
1.6	Goal 1	$74.1	$178.3	$170.1
1.6.1	*Measure 1*	$23.0	$73.1	$69.8
2	**HIV/AIDS, STD and TB Prevention**	**$898.0**	**$963.0**	**$978.8**
	HIV/AIDS, Research and Domestic	*$852.6*	*$920.2*	*$936.9*
2.1	Goal 1	$529.0	$532.6	$521.7
2.1.1	*Measure 1*[2]	$529.0	$532.6	$521.7
2.1.2	*Measure 2*	$3.5	$3.5	$3.5
2.1.3	*Measure 3*	$227.5	$229.0	$224.3
2.1.4	*Measure 4*	$121.7	$122.5	$120.0
2.1.5	*Measure 5*	$60.3	$60.7	$59.5
2.1.6	*Measure 6*	$24.3	$24.5	$24.0
2.1.7	*Measure 7*	$25.7	$25.9	$25.4
2.1.8	*Measure 8*	$25.7	$25.9	$25.4
2.2	Goal 2	$46.2	$46.5	$45.5
2.2.1	*Measure 1*[2]	N/A	N/A	N/A
2.2.2	*Measure 2*	$3.9	$4.0	$3.9
2.3	Goal 3	$147.3	$148.3	$145.3
2.3.1	*Measure 1*[2]	$147.3	$148.3	$145.3
2.3.2	*Measure 2*	$157.5	$158.6	$155.4
2.4	Goal 4	$118.9	$119.7	$117.3
2.4.1	*Measure 1*[2]	$38.6	$38.9	$38.1
2.4.2	*Measure 2*	$34.1	$34.3	$33.6
2.4.3	*Measure 3*	$11.2	$11.3	$11.1
2.5	Goal 5	$11.2	$11.3	$11.1
2.5.1	*Measure 1*[2]	$11.2	$11.3	$11.1
2.5.2	*Measure 2*	$0.4	$0.4	$0.4
2.5.3	*Measure 3*	$0.4	$0.4	$0.4
2.5.4	*Measure 4*	$0.1	$0.1	$0.1

FY 2009 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF FULL COST (DOLLAR IN MILLIONS)				
Unique ID	**Performance by HHS Strategic Goals and Performance Area**	**FY 2007**	**FY 2008**	**FY 2009**
	Viral Hepatitis	*$0.1*	*$0.1*	*$0.1*
2.6	Goal 6	$0.2	$0.1	$0.1
2.6.1	*Measure 1*	$0.0	$0.0	$0.0
2.6.2	*Measure 2*	$0.1	$0.1	$0.1
2.6.3	*Measure 3*	$0.2	$0.1	$0.1
2.6.4	*Measure 4*	$0.0	$0.0	$0.0
	SexuallyTransmitted Diseases	*$25.8*	*$24.3*	*$23.8*
2.7	Goal 7	$25.8	$24.3	$23.8
2.7.1	*Measure 1*	$14.7	$13.9	$13.6
2.7.2	*Measure 2*	$4.6	$4.4	$4.3
2.7.3	*Measure 3*	$5.2	$4.9	$4.8
2.7.4	*Measure 4*	$4.9	$4.6	$4.5
2.7.5	*Measure 5*	$9.8	$9.2	$9.1
2.7.6a	*Measure 6(a)*	$7.0	$6.6	$6.4
2.7.6b	*Measure 6(b)*	$1.8	$1.7	$1.7
2.7.7	*Measure 7*	$0.0	$0.0	$0.0
2.7.8	*Measure 8*	$1.0	$1.0	$1.0
	Tuberculosis	*$19.4*	*$18.3*	*$17.9*
2.8	Goal 8	$19.4	$18.3	$17.9
2.8.1	*Measure 1*	$65.1	$64.3	$63.0
2.8.2	*Measure 2*	$6.2	$5.9	$5.7
2.8.3	*Measure 3*	$1.7	$1.6	$1.6
2.8.4	*Measure 4*	$0.8	$0.8	$0.7
3	**Zoonotic, Vector-Borne, and Entric Diseases**	**$45.5**	**$48.1**	**$47.0**
3.1	Goal 1	$45.5	$48.1	$41.2
3.1.1	*Measure 1*	$22.1	$23.3	$20.0
	HEALTH PROMOTION			
6	**Birth Defects, Developmental Disabilities, Disability and Health**	**$12.0**	**$12.5**	**$11.9**
6.2	Goal 2	$12.0	$12.5	$11.9
6.2.1	*Measure 1*	$12.0	$12.5	$11.9
	GLOBAL HEALTH			
13.A	**Global Health - GAP**	**$102.9**	**$101.4**	**$100.5**
13.A.1	Goal 1	$67.1	$66.2	$65.5
13.A.1.1	*Measure 1*	$8.1	$7.9	$7.9
13.A.1.2	*Measure 2*	$4.7	$4.6	$4.6
13.A.1.3	*Measure 3*	$6.0	$6.0	$5.9
13.A.1.4	*Measure 4*	$4.7	$4.6	$4.6
13.A..2	Goal 2	$35.8	$35.3	$34.9
13.A.2.1	*Measure 1*	$4.3	$4.2	$4.2
13.A.2.2	*Measure 2*	$2.5	$2.5	$2.4
13.A.2.3	*Measure 3*	$3.2	$3.2	$3.1
13.A.2.4	*Measure 4*	$2.5	$2.5	$2.4
13.B	**Global Health - Immunization**	**$120.8**	**$119.1**	**$117.9**
13.B.1	Goal 3	$85.0	$83.8	$83.0
13.B.1.1	*Measure 1*	$7.7	$7.1	$7.1
13.B.1.2	*Measure 2*	$7.7	$7.1	$7.1
13.B.1.3	*Measure 3*	$16.2	$16.8	$16.6
13.B.2	Goal 4	$35.8	$35.3	$34.9
13.B.2.1	*Measure 1*	$4.7	$4.6	$4.5
13.B.2.2	*Measure 2*	$0.7	$0.7	$0.7
	Sub-total	***$4,514.4***	***$4,638.6***	***$4,710.0***

FY 2009 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF FULL COST (DOLLAR IN MILLIONS)				
Unique ID	**Performance by HHS Strategic Goals and Performance Area**	**FY 2007**	**FY 2008**	**FY 2009**
	HHS Strategic Goal 2.2			
	ENVIRONMENTAL HEALTH AND INJURY			
10	**Environmental Health**	**$77.9**	**$103.2**	**$89.7**
10.1	Goal 1	$10.6	$8.2	$7.1
10.1.1	*Measure 1*	$10.6	$8.2	$7.1
10.2	Goal 2	$67.2	$95.0	$82.6
10.2.1	*Measure 1*	$26.6	$37.6	$32.7
10.2.2	*Measure 2*	$29.2	$41.2	$35.8
11	**Injury Prevention and Control**	**$50.5**	**$49.8**	**$48.5**
11.1	Goal 1	$42.9	$42.3	$41.2
11.1.1	*Measure 1*	N/A	N/A	N/A
11.1.2	*Measure 2*	$1.3	$1.3	$1.2
11.2	Goal 2	$7.7	$7.6	$7.4
11.2.1	*Measure 1*	$0.2	$0.2	$0.1
11.2.2	*Measure 2*	$0.1	$0.1	$0.1
11.2.3	*Measure 3*	$0.1	$0.1	$0.1
12	**OCCUPATIONAL SAFETY AND HEALTH**			
12.1	Goal 1	$235.3	$263.2	$190.8
12.1.3	*Measure 3*	$235.3	$263.2	$190.8
12.2	Goal 2	$12.5	$14.0	$10.2
12.2.2	*Measure 2*	$12.5	$14.0	$10.2
12.2.3	*Measure 3*	N/A	N/A	N/A
	Sub-total	***$376.2***	***$430.3***	***$339.2***
	HHS Strategic Goal 2.3			
	HEALTH PROMOTION			
5	**Chronic Disease Prevention and Health Promotion**	**$694.8**	**$697.4**	**$664.4**
	Cancer			
5.1	Goal 1	$315.8	$315.4	$300.4
5.1.1	*Measure 1*	$21.2	$21.1	$20.1
5.1.2	*Measure 2*	$21.2	$21.1	$20.1
5.1.3	*Measure 3*	$28.4	$28.4	$27.0
	Tobacco			
5.2	Goal 2	$102.0	$99.1	$94.4
5.2.1	*Measure 1*	$5.7	$5.5	$5.2
5.2.2	*Measure 2*	$5.7	$5.5	$5.2
	Diabetes			
5.3	Goal 3	$83.0	$76.6	$73.0
5.3.1	*Measure 1*	$3.8	$3.3	$3.1
5.3.2	*Measure 2*	$3.8	$3.3	$3.1
	Heart Disease and Stroke			
5.4	Goal 4	$55.9	$55.9	$53.2
5.4.1	*Measure 1*	$1.7	$1.7	$1.6
5.4.2	*Measure 2*	$0.9	$0.9	$0.9
5.4.3	*Measure 3*	$0.9	$0.9	$0.9
	Nutrition and Physical Activity			
5.5	Goal 5	$61.4	$55.0	$52.4
5.5.1	*Measure 1*	$0.6	$0.5	$0.5
5.5.2	*Measure 2*	$2.9	$2.4	$2.3
	School Health			
5.6	Goal 6	$76.7	$95.5	$91.0
5.6.1	*Measure 1*	$1.9	$2.4	$2.3
5.6.2	*Measure 2*	$1.9	$2.4	$2.3
5.6.3	*Measure 3*	$1.5	$1.8	$1.7
5.6.4	*Measure 4*	$0.2	$1.0	$0.9
6	**Birth Defects, Developmental Disabilities, Disability and Health**	**$53.9**	**$56.0**	**$53.5**
6.1	Goal 1	$49.4	$51.3	$49.0
6.1.3	*Measure 3*	$0.4	$0.4	$0.4
6.1.4	*Measure 4*	$0.7	$0.7	$0.6
6.2	Goal 2	$4.5	$4.7	$4.5
6.2.3	*Measure 3*	$4.5	$4.7	$4.5
	PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT	**$99.0**	**$0.0**	**$0.0**
	Sub-total	***$847.7***	***$753.4***	***$717.9***

FY 2009 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF FULL COST (DOLLAR IN MILLIONS)				
Unique ID	**Performance by HHS Strategic Goals and Performance Area**	**FY 2007**	**FY 2008**	**FY 2009**
	HHS Strategic Goal 2.4			
	HEALTH INFORMATION SERVICES			
9	**Health Marketing**	**$49.8**	**$50.2**	**$73.1**
9.2	Goal 2	$49.8	$50.2	$73.1
9.2.1	*Measure 1*	$49.8	$49.8	$49.8
	ENVIRONMENTAL HEALTH AND INJURY			
10	**Environmental Health**	**$2.5**	**$3.6**	**$3.3**
10.2	Goal 2	$2.5	$3.6	$3.3
10.2.3	*Measure 3*	$2.5	$3.6	$3.3
16	**TERRORISM**			
16.2	Preparedness Goal 2	$67.7	$66.4	$65.6
16.2.1	*Measure 1*	$0.7	$0.7	$0.7
16.2.2	*Measure 2*	$24.2	$23.7	$23.4
16.3	Preparedness Goal 3	$45.6	$44.7	$44.2
16.3.1	*Measure 1*	$4.7	$4.6	$4.5
16.3.2	*Measure 2*	$4.7	$4.6	$4.5
16.3.3	*Measure 3*	$3.7	$3.6	$3.5
16.3.4	*Measure 4*	$2.1	$2.0	$2.0
16.3.5	*Measure 5*	$2.1	$2.0	$2.0
16.4	Preparedness Goal 4	$7.4	$7.2	$7.1
16.4.1	*Measure 1*	$3.9	$3.9	$3.8
16.5	Preparedness Goal 5	$41.2	$40.4	$39.9
16.5.1	*Measure 1*	$6.0	$5.9	$5.8
16.5.2	*Measure 2*	$6.0	$5.9	$5.8
16.5.3	*Measure 3*	$4.1	$4.0	$4.0
16.6	Preparedness Goal 6	$466.8	$457.4	$452.1
16.6.1	*Measure 1*	$4.7	$4.6	$4.5
16.6.2	*Measure 2*	$4.7	$4.6	$4.5
16.6.3	*Measure 3*	N/A	N/A	$170.0
16.6.4	*Measure 4*	$28.0	$27.4	$27.1
16.6.5	*Measure 5*	$28.0	$27.4	$27.1
16.6.6	*Measure 6*	$175.5	$172.0	$170.0
16.6.7	*Measure 7*	$4.7	$4.6	$4.5
16.9	Preparedness Goal 9	$746.6	$731.5	$723.1
16.9.1	*Measure 1*	$465.1	$455.7	$450.5
16.9.2	*Measure 2*	$4.5	$4.4	$4.3
16.9.3	*Measure 3*	$224.0	$219.4	$216.9
16.9.4	*Measure 4*	$35.1	$34.4	$34.0
	Sub-total	**$1,427.7**	**$1,401.3**	**$1,408.4**
	HHS Strategic Goal 3			
	HHS Strategic Goal 3.4			
14	**PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP**			
14.A	**Office of Minority Health**	**$2.8**	**$2.8**	**$2.8**
14.A.1	Goal 1	$0.7	$0.7	$0.7
14.A.1.1	*Measure 1*	$0.2	$0.2	$0.2
14.A.2	Goal 2	$0.7	$0.7	$0.7
14.A.2.1	*Measure 1*	$0.2	$0.2	$0.2
14.A.3	Goal 3[2]	$0.7	$0.7	$0.7
14.A.3.1	*Measure 1*	$0.0	$0.0	$0.0
14.A.3.2	*Measure 2*	$0.0	$0.0	$0.0
14.A.3.3	*Measure 3*	$0.0	$0.0	$0.0
14.A.3.4	*Measure 4*	$0.0	$0.0	$0.0
14.A.4	Goal 4	$0.7	$0.7	$0.7
14.A.4.1	*Measure 1*	$0.1	$0.1	$0.1
14.A.4.2	*Measure 2*	$0.1	$0.1	$0.1
	Sub-total	**$2.8**	**$2.8**	**$2.8**

FY 2009 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF FULL COST (DOLLAR IN MILLIONS)				
Unique ID	**Performance by HHS Strategic Goals and Performance Area**	**FY 2007**	**FY 2008**	**FY 2009**
	HHS Strategic Goal 4			
	HHS Strategic Goal 4.1			
	OCCUPATIONAL SAFETY AND HEALTH			
12	**Occupational Safety and Health**	**$92.0**	**$103.0**	**$74.6**
12.2	Goal 2	$92.0	$103.0	$74.6
12.2.1	*Measure 1*	$13.6	$15.2	$11.0
12.2.4	*Measure 4*	N/A	N/A	N/A
14	**PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP**			
14.C	**Office of Workforce and Development**	**$43.3**	**$40.0**	**$34.3**
14.C.1	Goal 1	$43.3	$40.0	$34.3
14.C.1.1	*Measure 1*	$38.9	$36.0	$30.9
	Sub-total	**$135.3**	**$143.0**	**$108.9**
	HHS Strategic Goal 4.2			
	INFECTIOUS DISEASES			
1	**Immunization and Respiratory Diseases**	**$18.5**	**$20.7**	**$21.0**
	Immunization Grant Program	*$18.5*	*$20.7*	*$21.0*
1.5	Goal 5	$18.5	$20.7	$21.0
1.5.1	*Measure 1*	$9.3	$10.3	$10.5
	HEALTH PROMOTION			
6	**Birth Defects, Developmental Disabilities, Disability and Health**	**$10.2**	**$10.6**	**$10.1**
6.1	Goal 1	$5.8	$6.0	$5.7
6.1.1	*Measure 1*	$5.8	$6.0	$5.7
6.2	Goal 2	$4.4	$4.6	$4.4
6.2.4	*Measure 4*	$4.4	$4.6	$4.4
	HEALTH INFORMATION SERVICES			
7	**Health Statistics**	**$154.7**	**$157.2**	**$165.9**
7.1	Goal 1	$154.7	$157.2	$165.9
7.1.1	*Measure 1*	N/A	N/A	N/A
7.1.2	*Measure 2*	$7.7	$7.9	$8.3
7.1.3	*Measure 3*	$7.7	$7.9	$8.3
	ENVIRONMENTAL HEALTH AND INJURY			
10	**Environmental Health**	**$90.5**	**$69.6**	**$60.5**
10.1	Goal 1	$90.5	$69.6	$60.5
10.1.2	*Measure 2*	$26.6	$20.5	$17.8
	OCCUPATIONAL SAFETY AND HEALTH			
12	**Occupational Safety and Health**	**$31.4**	**$35.1**	**$25.4**
12.1	Goal 1	$31.4	$35.1	$25.4
12.1.2	*Measure 2*	$22.0	$24.6	$17.8
14	**PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP**			
14.C	**Office of Workforce and Development**	**-**	**-**	**-**
14.C.2	Goal 2 [3]	$0.0	$0.0	$0.0
14.C.2.1	*Measure 1*	$0.0	$0.0	$0.0
	Sub-total	***$305.3***	***$293.2***	***$283.0***
	HHS Strategic Goal 4.3			
	HEALTH PROMOTION			
6	**Birth Defects, Developmental Disabilities, Disability and Health**	**$75.8**	**$78.8**	**$75.2**
6.1	Goal 1	$10.2	$10.6	$10.1
6.1.2	*Measure 2*	$10.2	$10.6	$10.1
6.2	Goal 2	$65.7	$68.2	$65.1
6.2.2	*Measure 2*	$2.4	$2.5	$2.4
	OCCUPATIONAL SAFETY AND HEALTH			
12	**Occupational Safety and Health**	**$313.7**	**$351.0**	**$253.6**
12.1	Goal 1	$313.7	$351.0	$253.6
12.1.1	*Measure 1*	$47.1	$52.6	$38.0
	Sub-total	***$389.5***	***$429.8***	***$328.8***

FY 2009 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF FULL COST (DOLLAR IN MILLIONS)				
Unique ID	**Performance by HHS Strategic Goals and Performance Area**	**FY 2007**	**FY 2008**	**FY 2009**
	HHS Strategic Goal 4.4			
	HEALTH INFORMATION SERVICES			
9	**Health Marketing**	**$99.7**	**$106.7**	**$121.8**
9.1	Goal 1	$31.1	$43.9	$36.5
9.1.1	*Measure 1*	$31.1	$43.9	$36.5
9.3	Goal 3	$18.7	$12.5	$12.2
9.3.1	*Measure 1*	$18.7	$18.7	$18.7
	Sub-total	***$99.7***	***$106.7***	***$121.8***
	Total	**$8,126.0**	**$8,224.0**	**$8,041.4**

[1] *Includes VFC funding.*

[2] *This is an overarching long-term measure.*

[3] *The activities covered by these goals & measures are funded by other areas within CDC.*

N/A signifies retired goals and measures, measures Full Cost was not calculated for, or measures not reported in a fiscal year.

LIST OF PROGRAM EVALUATIONS

The following program evaluations were conducted for CDC programs.

Immunization and Respiratory Diseases

Section 317 Evaluation

In response to OMB's 2002 PART review of the Section 317 Program, a comprehensive evaluation was initiated to assess the effectiveness of the program's current operations and performance and to develop systematic mechanisms to improve efficiency, cost-effectiveness, and accountability. To date, the econometric model component of the evaluation designed to meet OMB's rigorous criteria documented program operations or infrastructure investments contribute significantly to vaccination coverage levels. The phase III evaluation report was completed in June 2007. The findings and recommendations are being reviewed by management.

Vaccine Efficacy

On November 14, 2007 the Journal of the American Medical Association (JAMA) published "Historical Comparisons of Morbidity and Mortality for Vaccine-Preventable Disease in the United States," The article serves as a key program evaluation documenting morbidity and mortality before and after widespread implementation of national vaccine recommendations for 13 vaccine-preventable diseases for which recommendations were in place prior to 2005. http://jama.ama-assn.org/cgi/reprint/298/18/2155

Global Measles Program

An independent evaluation of the management of measles funds was performed by an external consultant. The final report was delivered in December 2007. The recommendations are being reviewed by management for implementation in 2008.

EVALUATIONS INCLUDED IN HHS PROGRAMS EVALUATIONS DATABASE FOR FY 2007

1. What is the current state of Heart Disease and Stroke Prevention policy-making in the U.S. and what policy tools are available to advance grantee capacity?
    a. Link: http://www.cdc.gov/dhdsp/dhdspleg/
2. How have potential users been made aware of Protocol for Assessing Community Excellence in Environmental Health and what factors contributed to the decision to implement this program?
    a. Link: http://www.cdc.gov/nceh/ehs/CEHA/Docs/PACE_EH_Final_Report_Process_Evaluation.pdf
3. Has the Mining Research Program made an impact in the workplace which has resulted in a reduction of occupational injuries, illness, and death?
    a. Link: Mining Safety and Health Research at NIOSH http://books.nap.edu/catalog.php?record_id=11850
4. How does a surveillance presence for Intimate Partner Violence and Child Maltreatment impact violence prevention activities?
    a. Link: http://aspe.hhs.gov/pic/fullreports/07/8749.pdf

5. What activities can state Early Hearing Detection and Intervention (EHDI) programs implement to reduce the loss to follow-up of newborns screened by universal newborn hearing screening?
    a. Link: http://www.cdc.gov/ncbddd/ehdi/documents/research/Loss_Followup_Ongoing.pdf
6. How can state and territorial health departments better plan and evaluate state tobacco control programs in order to reduce smoking prevalence among adults and youth?
    a. Link: http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/key_outcome/00_pdfs/Key_Indicators.pdf
7. Did the Fire Fighter Fatality Investigation and Prevention Program (FFFIPP) influence firefighters' safety knowledge, attitudes and behavior and how can this impact be improved?
    a. http://aspe.hhs.gov/pic/fullreports/06/8299.pdf

DISCONTINUED MEASURES TABLE

HIV/AIDS, VIRAL HEPATITIS, STD, AND TB PREVENTION

Dropped Annual Measure	FY	Target	Result
Goal 1 PM1: Reduce the rate of HIV infections diagnosed each year among people under 25 years of age. [O]	*2007*	<4,000 cases in 30 areas	11/2008
	2006	Overall: 2,420 reported cases in 30 areas	03/2008
	2005	Overall: 1,800 reported cases in 25 states	2,700 in 25 states; (Unmet) 3,605 in 30 areas 7.4/100,000 in 33 states
	2004	Overall: 1,900 reported cases in 25 states	2,606 in 25 states; (Unmet) 3,465 in 30 areas (Unmet);
	2003	Baseline	2,286 in 25 states; 3,134 in 30 areas; 6.9/100,000 in 33 states
Goal 1 PM 2: Decrease the number of perinatally acquired AIDS cases, from the 1998 base of 247 cases. [O]	*2007*	<100 cases	11/2008
	2006	<100 cases	03/2008
	2005	<100 cases	58 (Exceeded)
	2004	<100 cases	48 (Exceeded)
	2003	<139 cases	69 (Exceeded)
Goal 2 PM 1: Among HIV-infected persons 18 years of age and over, reduce the proportion that had high-risk sex with a negative partner or partner of unknown status. [O]	*2007*	<11%	11/2008
	2006	<11%	Not available (Unmet)
	2005	<10%	Not available (Unmet)
	2004	<10%	13.4% (median) (Unmet)
	2003	N/A	17.0% (median)
Goal 3 PM 1: Among persons with HIV infection, increase the proportion diagnosed before progression to AIDS. [O]	*2007*	Dropped/Revised	N/A
	2006	79%	N/A
	2005	80%	77% (Unmet)
	2004	80%	78% (Unmet)
	2003	N/A	78% Data are from 30 areas with stable HIV reporting systems
Goal 3 PM 2: Increase the percentage of HIV-positive tests with post-test counseling sessions reported from CDC funded test sites. [O]	*2007*	Dropped/Revised	N/A
	2006	75%	N/A
	2005	80%	N/A
	2004	80%	71% (Unmet)
	2003	75%	71% (Unmet)
Goal 4 PM 1: Increase the proportion of HIV-infected people who received some form of medical care within 3 months of HIV diagnosis. [O] (Data are from interviews taken from a sample of persons in 16 areas.)	*2007*	Dropped/Revised	N/A
	2006	80%	Not available (Unmet)
	2005	80%	Not available (Unmet)
	2004	80%	86.1% (Exceeded)
	2003	N/A	83.3%

Dropped Annual Measure	FY	Target	Result
Goal 5 PM 1: Increase the number of states and the District of Columbia that conduct HIV case reporting in adults and adolescents.	*2007*	50 states and D.C.	50 states and DC; 48 states and DC use confidential, name-based reporting (Met)
	2006	50 states and D.C.	50 states and DC; 46 states and DC use confidential, name-based reporting (Met)
	2005	50 states and D.C.	50 states and DC; 38 use confidential, name-based reporting (Met)
	2004	50 states and D.C.	50 states and DC; 38 use confidential, name-based reporting (Met)
	2003	50 states	49 states and D.C.; 34 use confidential, name-based reporting (Unmet)
Goal 6 PM 1: Reduce the prevalence of chlamydia among high-risk women under age 25 by 15%. [O]	*2007*	9.3%	10/2008
	2006	9.3%	13.1%
	2002	Baseline	10.1%
Goal 6 PM 2: Reduce the prevalence of chlamydia among women under age 25, in publicly funded family planning clinics by 15%. [O]	*2007*	6.3%	10/2008
	2006	6.3%	6.7%
	2002	Baseline	5.6%
Goal 6 PM 3: Reduce the incidence of gonorrhea in women aged 15 to 44 by 15%. [O]	*2007*	278/100,000	10/2008
	2006	278/100,000	290/100,000
	2002	Baseline	279/100,000
Goal 7 PM 1a): Reduce the incidence of P&S syphilis in men per 100,000 population by 7%. [O]	*2007*	4.5/100,000	10/2008
	2006	Establish Baseline	5.7/100,000
Goal 7 PM 1b): Reduce the incidence of P&S syphilis in women per 100,000 population by 65%. [O]	*2007*	0.8/100,000	10/2008
	2006	0.58/100,000	1.0/100,000
	2002	Baseline	1.1/100,000
Goal 7 PM 2: Reduce the incidence of congenital syphilis per 100,000 live births. [O]	*2007*	8.8/100,000	10/2008
	2006	8.8/100,000	8.5/100,000
	2002	Baseline	11.4/100,000
Goal 7 PM 3: Reduce the racial disparity of P&S syphilis by 63% (reported ratio is black:white). [O]	*2007*	5.6 to 1	10/2008
	2006	5.6 to 1	5.9 to 1
	2002	Baseline	8.1 to 1
Goal 8 PM 1. Decrease the number of persons with TB among US-born persons, foreign-born persons, and overall (per 100,000 population). [O]	*2007*	US-born 1.9 ; Foreign-born 21.2; Overall 3.9	9/2008
	2006	US-born 1.9 ; Foreign-born 21.2; Overall 3.9	US-born 2.3; Foreign-born 22.0; Overall 4.6
	2004	Baseline	US born: 2.6; Foreign-born: 22.8; Overall: 4.9
Goal 8 PM 2: Increase the percentage of TB patients who complete a course of curative TB treatment within 12 months of initiation of treatment (some patients require more than 12 months). [O]	*2007*	88%	9/2010
	2006	88%	9/2009
	2005	88%	9/2008
	2004	88%	82.3%

Dropped Annual Measure	FY	Target	Result
	2003	88%	81.5% (Unmet)
	2002	88%	80.9% (Unmet)
	1999	Baseline	67.6%
Goal 8 PM 3: Increase the percentage of TB patients with initial positive cultures who also have drug susceptibility results. [O]	*2007*	95%	9/2008
	2006	95%	92.2%
	2005	95%	94.6% (Unmet)
	2004	95%	93.9% (Unmet)
	1994	Baseline	74.7%
Goal 8 PM 4: Increase the percentage of contacts of infectious (Acid-Fast Bacillus (AFB) smear-positive) cases that are placed on treatment for latent TB infection and complete a treatment regimen. [O]	*2007*	43%	12/2010
	2006	59%	12/2009
	2005	61%	12/2008
	2004	61%	43.3%
	2003	63%	43% (Unmet)
	2002	63%	42% (Unmet)
	1999	Baseline	45.5%
Goal 9 PM 1: By 2010, reduce the number of new cases of hepatitis A to 2.25 new cases per 100,000 population [O]	*2007*	2.5 new cases	9/2008
	2006	2.6 new cases	1.2/100,000
	2005	2.6 new cases	1.5/100,000
	1997	Baseline	11.3

PREPAREDNESS, DETECTION, AND CONTROL OF INFECTIOUS DISEASES

Dropped Annual Measure	FY	Target	Result
Goal 1 PM 1: Reduce the number of courses of antibiotics for ear infections for children < 5 years to 57 courses per 100 children. [O]	*2006*	60 courses	2/2008
	2005	61 courses	47 (Exceeded)
	2004	62 courses	42 (Exceeded)
	2003	63 courses	53 (Exceeded)

CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS

Dropped Annual Measure	FY	Target	Result
Goal 1 PM 1: Reduce the proportion of heart disease and stroke deaths that occur before transport to emergency services in states funded for basic implementation programs. [O]	*2006*	Heart disease deaths 45%; Stroke deaths 43%	12/2009
	2005	Heart disease deaths 45%; Stroke deaths 43%	12/2008
	2004	Heart disease deaths 45%; Stroke deaths 43%	Heart disease deaths 51% (Unmet) Stroke deaths 47% (Unmet)
	2003[1]	N/A	Heart disease deaths 49%; Stroke deaths 46%
	2002	N/A	Heart disease deaths 48%; Stroke deaths 45%
	2001	Baseline	Heart disease deaths 47%; Stroke deaths 44%
Goal 2 PM 1: Excluding invasive cervical cancers diagnosed on an initial screen in NBCCEDP, lower the age-adjusted rate of invasive cervical cancer in women aged 20 and older. [O]	*2006*	<14/100,000	15/100,000 (Unmet)
	2005	<14/100,000	15/100,000 (Unmet)
	2004	<15/100,000	17/100,000 (Unmet)
	2003	<16/100,000	15/100,000 (Exceeded)
	2002	<22/100,000	15/100,000 (Exceeded)
Goal 3 PM 1: Increase the number of women screened. [O] Breast: mammogram or Clinical Breast Examination (CBE) Cervical: Pap Smear	*2006*	Breast 401,000; Cervical 280,000	2/2008
	2005	Breast 401,000; Cervical 280,000	Breast 572,173 (Exceeded) Cervical 344,959 (Exceeded)
	2004	Breast 381,682; Cervical 275,000	Breast 558,846 (Exceeded) Cervical 329,645 (Exceeded)
	2003	N/A	Breast 537,619; Cervical 304,407
	2002	N/A	Breast 394,146; Cervical 280,330
	2000	Baseline	Breast: 229,000; Cervical: 247,192
Goal 3 PM 2: Increase the percentage of newly enrolled women who have not received a Pap test within the past 5 years. [O]	*2006*	Cervical 25%	2/2008
	2005	Cervical 25%	21.8% (Unmet)
	2004	Cervical 22.5%	22.1% (Unmet)
	2003	Cervical 22.5%	21.3% (Unmet)
	2002	N/A	22.2%
	2000	Baseline	Cervical 21.7%
Goal 3 PM 3: Increase the percentage of women with abnormal results who receive a final diagnosis within 60 days of screening. [O] Breast: abnormal mammogram (suspicious of abnormality, highly suggestive of malignancy, or assessment incomplete) and/or abnormal CBE Cervical: abnormal Pap includes high grade SIL,	*2006*	Breast 87.5%; Cervical 64.5%	2/2008
	2005	Breast 87.5%; Cervical 64.5%	Breast 83.8% (Unmet) Cervical 65.6% (Met)
	2004	Breast 86.5%; Cervical 64%	Breast 80.7% (Unmet) Cervical 62.6% (Unmet)
	2003	N/A	Breast 81.4%; Cervical 62.0%

Dropped Annual Measure	FY	Target	Result
squamous cancer, or abnormal glandular cells	*2002*	N/A	Breast 82.8%; Cervical 63.0%
	2000	Baseline	Breast: 82.2%; Cervical: 61.2%
Goal 3 PM 4: Increase the percentage of women with cancer who start treatment within 60 days of diagnosis. [O]	*2006*	Breast 95.5%; Cervical 92.5%	2/2008
	2005	Breast 95.5%; Cervical 92.5%	Breast 93.7% (Unmet) Cervical 92.6% (Met)
	2004	Breast 95%; Cervical 92%	Breast 93.1% (Unmet) Cervical 87.6% (Unmet)
	2003	N/A	Breast 93.0% Cervical 91.9%
	2002	N/A	Breast 92.9%; Cervical 88.6%
	2000	Baseline	Breast: 94%; Cervical: 88%
Goal 3 PM 5: Cervical: Increase the percentage of women with precancerous lesions who start treatment within 90 days of diagnosis (includes CIN (cervical intraepithelial neoplasia) II, CIN III, and CIS). [O]	*2006*	94.5%	2/2008
	2005	94.5%	91.1% (Unmet)
	2004	94%	90.4% (Unmet)
	2003	N/A	89.0%
	2002	N/A	90.3%
	2000	Baseline	92.4%
Goal 4 PM 1: For states receiving CDC funding for Diabetes Prevention and Control Programs (DPCPs), increase the percentage of persons with diabetes who receive annual eye and foot exams. [O]	*2006*	Eye 75%; Foot 70%	2/2008
	2005	Eye 75%; Foot 70%	Eye 60.6% (Unmet); Foot 66.0% (Unmet)
	2004	Eye 72%; Foot 62%	Eye 61.9% (Unmet); Foot 66.6% (Exceeded)
	2003	Eye 72%; Foot 62%	Eye 61.3% (Unmet); Foot 67.4% (Exceeded)
	2002	Eye 72%; Foot 62%	Eye 64.2% (Unmet); Foot 66.6% (Exceeded)
Goal 4 PM 2: For states receiving CDC funding for DPCPs, increase the percentage of persons with diabetes who receive at least two A1c measures per year. [O]	*2006*	72.5%	68.0% (Unmet)
	2005	72.5%	64.3% (Unmet)
	2004	72.5%	68.8% (Unmet)
	2003	N/A	63.3%
	2002	Baseline	62.0%
Goal 4 PM 3: Increase the number of DPCPs that promote health system approaches among those who are at high risk for developing diabetes.	*2006*	5	5 (Met)
	2005	5	5 (Met)
	2004	5	5 (Met)
	2002	Baseline	0
Goal 5 PM 1: Increase the number of nutrition and physical activity interventions that are implemented and evaluated in funded states.	*2006*	25 interventions	132 (Exceeded)
	2005	20 interventions	81 (Exceeded)
	2004	12 interventions	12 (Met)
	2002	Baseline	0 interventions

Dropped Annual Measure	FY	Target	Result
Goal 6 PM 1: Collect qualitative and quantitative data in REACH 2010 communities to evaluate community capacity-building, intervention strategies, systems change, change among change agents, and change in risk/protective behaviors.	*2006*	REACH 2010 Risk Factor Survey data (quantitative) on changes in risk/protective behaviors will be collected and disseminated in 100% of the communities with health priority areas in breast and cervical cancer, cardiovascular diseases, and diabetes, (excluding the REACH Elderly projects); 85% of REACH 2010 communities will collect and disseminate data (qualitative).	100%/ 85% (Met)
	2005	Same as above	100%/85% (Met)
	2004	REACH 2010 Risk Factor Survey data (quantitative) on changes in risk/protective behaviors will be collected and disseminated in 100% of the communities with health priority areas in breast and cervical cancer, cardiovascular diseases, and diabetes, (excluding the REACH Elderly projects); 60% of REACH 2010 communities will collect and disseminate data (qualitative).	100%/60% (Met)

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

Dropped Annual Measure	FY	Target	Result
Efficiency Measure 1: Increase the number of autism cases included in the data coordinating center, resulting in savings of program and staff time and expediting efforts to understand the prevalence and find the causes of autism. [E]	*2006*	250	2/2008
Goal 1 PM 1: Decrease the percentage of women who report any alcohol consumption during pregnancy. [O]	*2006*	8.0%	12/2008
	2005	8.5%	2/2008
	2004	10.0%	10.8% (Unmet)
	2003	11.5%	10.6 % (Exceeded)
	1999	Baseline	12.8%
Goal 1 PM 2: Reduce by 1% per year the number of children born with spina bifida and anencephaly through promotion of folic acid consumption by women of reproductive age. [O]	*2006*	4% reduction	12/2009
	2005	3% reduction	12/2008
	2004	2% reduction	2/2008
	2003	1% reduction	2,021 (Unmet)
	2000	Baseline	1,932
Goal 2 PM 1: By 2010, decrease to 10% the percentage of newborns that screen positive for hearing loss but are lost to follow-up. [O]	*2006*	22%	12/2008
	2005	25%	2/2008
	2004	30%	23% (Exceeded)
	2003	35%	31% (Exceeded)

INJURY PREVENTION AND CONTROL

Dropped Annual Measure	FY	Target	Result
Goal 1 PM 1: Reduce the incidence of rape or attempted rape by increasing the number of school and college-aged people reached through educational programs. (This measure will be retired after reporting in 2007)	*2006*	3% increase from previous year	2,505,760 (Met)
	2005	3% increase from previous year	3,195,563 (Unmet)
	2004	Establish baseline	3,328,735 (Met)
Goal 1 PM 2: Among the states receiving funding from CDC, reduce deaths from residential fire. (This measure will be retired after reporting in 2009) [O]	*2006*	1.27 per 100,000	2/2008
	2005	1.28 per 100,000	1.18 per 100,000 (Exceeded)
	2004	1.29 per 100,000	1.18 per 100,000 (Exceeded)
	2003	1.30 per 100,000	1.17 per 100,000 (Exceeded)
	2001	Baseline	1.26 per 100,000

OCCUPATIONAL SAFETY AND HEALTH

Dropped Annual Measure	FY	Target	Result
Goal 1 PM 2: Increase the relevance of occupational safety and health research for future improvements in workplace protection.	*2005*	Evaluate relevance of first 1/5 of CDC NIOSH program activities with 80% rating 4 or 5 (on a scale of 1 to 5, with 5 being the highest) as judged by independent panels of external customers, stakeholders, and experts.	Met
	2004	Finalize arrangements with National Academies (NA) for relevance review.	Met
	2003	Conduct baseline evaluation among safety and health professionals of CDC NIOSH research relevance for practical workplace results.	Met
Goal 2 PM 1: Increase the quality, relevancy, and usefulness of CDC information and recommendations to occupational safety and health professionals, workers, employers, government, the scientific community, and the public.	*2006*	Increase the number of occupational safety and health professionals who use CDC as a source for occupational safety and health information; continue to establish baseline.	OMB approval for survey received 11/2007 Unable to report on target
	2005	Increase the number of occupational safety and health professionals who use CDC as a source for occupational safety and health information; continue to establish baseline.	Revised survey instrument (Unmet)
	2004	Increase the use of CDC information and recommendations by occupational safety and health professionals, workers, employers, government, the scientific community, and the public.	79% (Met)
	2003	Establish baseline on the percentage of occupational safety and health professionals who use occupational safety and health	74% (Met)

Dropped Annual Measure	FY	Target	Result
		information published within the last 12 months by CDC.	
Goal 2 PM 4: Increase workplace use of control and personal protective technologies in targeted sectors. [O] A) Increase the availability of CBRN-certified respirators for use during a CBRN event to a specified % of the professional firefighters. B) Increase the percentage of U.S. pavers with installed engineering controls to a specified %.	*2006*	B) 90%	90% (Met)
	2005	A) 15% B) 80%	A) 46% (Exceeded) B) 80% (Met)
	2004	A) 10% B) 70%	A) 13% (Exceeded) B) 70% (Met)
	2003	A) 3% B) Establish baselines	A) 3% (Met) B) 60% (Met)

PUBLIC HEALTH WORKFORCE AND CAREER DEVELOPMENT

Dropped Annual Measure	FY	Target	Result
1. Increase the efficiency with which the OMB Clearance package for Epi-Aids is processed, resulting in reduced number of staff hours spent in preparing the package for submission. [E]	*2006*	50 hours	20 hours (Met)
	2005	50 hours	18 hours (Met)
	2004	50 hours	22 hours (Met)
	2003	Baseline	200 hours

TERRORISM PREPAREDNESS AND EMERGENCY RESPONSE

Dropped Annual Measure	FY	Target	Result
Goal 2 PM 1: Increase the number of state and local public health professionals who use Epi-X to share intelligence regarding outbreaks and other emerging health events including those suggestive of bioterrorism. (This measure will be retired after data have been reported for FY 2007).	*2007*	3,400	4,885 (Exceeded)
	2006	3,200	4,220 (Exceeded)
	2005	3,000	3,300 (Exceeded)
	2004	2,100	2,812 (Exceeded)
Goal 3 PM 2: Maintain at 150 the number of toxic substances likely to be used in chemical terrorism that can be rapidly measured in blood and urine. (This measure will be retired after data have been reported for FY 2007).	*2007*	150 substances	150 (Met)
	2006	150 substances	150 (Met)
	2005	150 substances	150 (Met)
	2004	150 substances	150 (Met)
Goal 4 PM 1: Increase the number of states and major metropolitan areas with access to Epi-X.	*2007*	225	228 (Exceeded)
	2006	150	154 (Exceeded)
	2005	125	137 (Exceeded)
	2004	100	100 (Met)
Properly equipped public health emergency response teams will be onsite within 4 hours of notification by local public health officials, to assess the public health impact and determine the appropriate public health intervention in response to Category A agents.	*2010*	100%	---
	2007	70%	[1]
	2006	50%	---
	2005	25%	Unmet
Percentage of state public health agencies improve their capacity to respond to exposure to chemicals or category A agents by annually exercising scalable plans and implementing corrective action plans to minimize any gaps identified.	*2008*	100%	---
	2010	100%	---
	2007	100%	[2]
	2006	100%	94%
	2005	25%	94%
Percentage of state and local public health agencies will be in compliance with CDC recommendations for using standards-based, electronic disease surveillance systems for appropriate routine public health information collection, analysis and reporting appropriate public health authorities.	*2009*	90%	
	2008	85%	---
	2007	75%	[3]
	2006	65%	---
	2005	100%	56%

[1] In December 2007, a revised measure and associated baseline and targets were negotiated between CDC and OMB for replacement of this measure. The new measure reads: *Percentage of public health agencies that directly receive CDC PHEP funding that, at least once/year, re-test a response following completion of corrective action(s) identified in a prior actual or simulated response*.

[2] In December 2007, a revised measure and associated baseline and targets were negotiated between CDC and OMB for replacement of this measure. The new measure reads: *Percentage of public health agencies that directly receive CDC PHEP funding that can convene within 60 minutes of notification a team of trained staff that can make decisions about appropriate response and interaction with partners.*

[3] In December 2007, a revised measure and associated baseline and targets were negotiated between CDC and OMB for replacement of this measure. The new measure reads: *Percentage of state public health laboratories that directly receive CDC PHEP funding that can correctly subtype E. Coli O157:H7 and submit the results into a national reporting system within 4 working days for 90% of the samples received.*

DATA SOURCE AND VALIDATION

Immunization and Respiratory Diseases – 317 Program		
Measure Unique Identifier	**Data Source**	**Data Validation**
1.E.1	Grantee annual report (VFC Management Survey), grantee interviews, and site visits were used to gather the baseline information. A VMBIP semi-annual survey instrument is being developed and will be administered to grantees to track vaccine storage locations.	Data submitted from grantees will be analyzed by the CDC program staff and validated through a regularly scheduled review process.
1.1.1 – 1.1.3	National Notifiable Disease Surveillance System (NNDSS), National Congenital Rubella Syndrome Registry (NCRSR), Active Bacterial Core Surveillance (ABCs), Emerging Infections Programs.	NNDSS - CDC receives reports of notifiable diseases from the 50 state health departments, New York City, the District of Columbia, and five U.S. Territories. These reports are initiated when health care providers suspect or diagnose a case of a notifiable disease. Clinical laboratories also report results consistent with reportable diseases. Reporting of nationally notifiable diseases to CDC by the states is voluntary and only mandated (i.e., by state legislation or regulation) at the state level. All case reports, especially for low incidence and internationally quarantinable diseases, must be verified by the appropriate state officials. NNDSS case counts are likely incomplete, and therefore, these data are considered to represent a minimum number of cases. State reporting practices and some administrative procedures used in processing the NNDSS data may impact surveillance data reports and analyses. CDC staff provides technical assistance relevant for data verification to ensure data accuracy, completeness, and timeliness. Specifically, assistance includes: computer specifications and software for reporting from state and territorial health departments, development and implementation of procedures to validate surveillance data, and identification of incomplete records, transmission errors, and deviations from expected numbers. NCRSR - CDC maintains the NCRSR with supplemental information to NNDSS. The registry includes data only on cases classified as confirmed or compatible. Cases are also classified as indigenous (exposure within the U.S.) and imported (exposure outside the U.S.) and are tabulated by year of birth. In contrast, cases reported to the NNDSS are tabulated by year of report. ABCs is an active laboratory and population-based surveillance system for invasive bacterial pathogens of public health importance, and currently operates in 10 sites in the U.S. For each case of invasive disease in the surveillance population, a case report with basic demographic information is completed and bacterial isolates are sent to CDC and other reference laboratories for additional laboratory evaluation. The ABCs program provides routine laboratory audits to ensure the completeness of data collection. Each month, CDC staff review data and communicate potential errors to state personnel for evaluation. Performance standards for active surveillance have been established in each site to permit aggregation of data collected via somewhat

Immunization and Respiratory Diseases – 317 Program		
Measure Unique Identifier	**Data Source**	**Data Validation**
		different approaches. Detailed instructions for completion of case report forms ensure consistency across sites. Timeliness and completeness of reporting in ABCs is evaluated using threshold percentages of isolate collection and enrollment into special studies. Surveillance "fatigue" or operational problems are assessed using isolate shipping schedules, audit sensitivities, and the timeliness of the audit data being completed by set deadlines.
1.2.1	Childhood data are collected through the National Immunization Survey (NIS) and reflect calendar years.	The NIS uses a nationally representative sample and provides estimates of vaccination coverage rates that are weighted to represent the entire population, nationally, and by region, state, and selected large metropolitan areas. The NIS, a telephone-based survey, is administered by random-digit-dialing to find households with children aged 19 to 35 months. Parents or guardians are asked about the vaccines, with dates, that appear on the child's "shot card" kept in the home; demographic and socioeconomic information is also collected. At the end of the interview with parents or guardians, survey administrators request permission to contact the child's vaccination providers. Providers are then contacted by mail to provide a record of all immunizations given to the child. Examples of quality control procedures include 100% verification of all entered data with a sub-sample of records independently entered. The biannual data files are reviewed for consistency and completeness by CDC's National Center for Immunization and Respiratory Diseases, Immunization Services Division - Assessment Branch and CDC's National Center for Health Statistics' Office of Research and Methodology. Random monitoring by supervisors of interviewers' questionnaire administration styles and data entry accuracy occurs daily. Annual methodology reports and public use data files are available to the public for review and analysis.
1.2.2	Adolescent data was collected through the National Health Interview Survey through 2003 and will be tracked again through the NIS-Teen Survey starting in 2007. The NIS-Teen data reported in 2007 were collected fourth quarter 2006.	The NIS Teen Survey was initiated in FY 2006 and provides national level estimates of vaccination coverage for 13-17 year old adolescents. It follows the same methodology of the NIS except that it is conducted only in the fourth quarter of the year. The NIS Teen Survey may be expanded in FY 2008 to provide vaccination coverage estimates by state and selected large metropolitan areas.
1.3.1 – 1.3.2	National Health Interview Survey (NHIS)	NHIS is a cross-sectional household interview survey. Households chosen for interviews are a probability sample representative of the target population. The annual response rate is more than 90 percent of eligible households in the sample. NHIS has three modules: 1) The basic module remains largely unchanged from year to year and allows for trend analysis. Data from more than one year can also be pooled to increase the sample size for analytic purposes. The basic module contains a family core, a sample adult core, and a child core through which data are collected on the family unit and from one randomly selected adult and child. 2) Periodic modules collect more detailed information on some of the topics included in the basic module. 3) Topical modules

Immunization and Respiratory Diseases – 317 Program		
Measure Unique Identifier	**Data Source**	**Data Validation**
		respond to new data needs as they arise. Data are collected through a personal household interview conducted by staff employed and trained by the U.S. Census according to procedures delineated by CDC. Data are reviewed and analyzed extensively to ensure their validity and reliability. The survey sample is designed to yield estimates that are representative and that have acceptably small variations. Before the actual survey, cognitive testing is performed by CDC's Questionnaire Design Research laboratory, and pretests are conducted in the field. Once collected, data are carefully edited, checked, and compared to data from earlier surveys and/or independent sources. Staff members calculate descriptive statistics and perform in-depth analyses, which result in feedback on the analytic usefulness of the data.
1.4.1	The Active Bacterial Core surveillance (ABCs)/Emerging Infections Program Network	The data are collected by 10 states through active contact with all clinical laboratories in population catchment areas; the data are sent to CDC monthly for review, editing and cleaning. States conduct audits for missed cases either monthly or in some cases bi-yearly. Pneumococcal isolates are collected and validated at three quality-controlled reference laboratories.
1.5.1	Vaccine Safety Datalink (VSD)	Annual reports and other published information from the VSD-participating managed care organizations.

Immunization and Respiratory Diseases – Influenza		
Measure Unique Identifier	**Data Source**	**Data Validation**
1.6.1	International bi-lateral cooperative agreement data and specimens received through the WHO Global Influenza Surveillance Network	CDC provides on-site technical assistance and reviews and analyzes the data for submittal of influenza samples and isolates for seasonal and pandemic influenza. Given that global coverage is necessary for both routine influenza virus monitoring and development of capacity to identify avian influenza for containment and response, the ability to test avian and other influenza and submit timely specimens is critical. Increasing geographic participation and enhancing capacity in more countries greatly increases the probability of detecting a case or cluster of H5N1.

HIV/AIDS, Viral Hepatitis, STD, and TB Prevention – Domestic HIV/AIDS Research		
Measure Unique Identifier	**Data Source**	**Data Validation**
2.E.1	HIV/AIDS Reporting System (HARS) is used to collect state HIV and AIDS data, financial assistance information is drawn from administrative records.	CDC conducts validation and evaluation studies of data systems which track AIDS deaths and HIV diagnosis to determine the quality of data generated by them.
2.1.1	HIV/AIDS Incidence Surveillance in 34 states	CDC conducts validation and evaluation studies of the data systems which monitor HIV incidence to determine the quality of data generated by them. The first national estimates will be generated from those areas with fully operational data collection systems. These areas are: Alaska, Arizona, Colorado, Connecticut, Florida, Georgia, Indiana, Louisiana, Michigan, Missouri, Mississippi, North Carolina, New Jersey, New York City, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, and Virginia. Additional states will be included as their data collection systems become fully operational.
2.1.2 – 2.1.5	HIV/AIDS Reporting System (eHARS)	CDC conducts validation and evaluation studies of the data systems which monitor HIV/AIDS to determine the quality of data generated by them. As of December 2005, 33 states have mature, stable HIV surveillance systems to allow for trend analysis. These states are: Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Iowa, Indiana, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New York, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. The period of time between a diagnosis of HIV or AIDS and the arrival of a case report at CDC is called the "reporting delay". In order to provide the best estimates of recent trends, HIV and AIDS surveillance data are analyzed by date of diagnosis and are statistically adjusted for reporting delays and incomplete information on some cases. CDC requires a minimum of 12 months after the end of a calendar year to provide accurate trend data.
2.1.6	Program Evaluation and Monitoring System (PEMS)	CDC evaluates the data systems used to report prevention program activity and develops guidelines for implementation, data entry and program monitoring to determine the quality of data generated by them.
2.1.7	Replicating Effective Programs (REP) Project data	Internal program data are routinely monitored and cross-checked to ensure rapid movement of newly identified evidence-based prevention intervention onto field practice.

HIV/AIDS, Viral Hepatitis, STD, and TB Prevention – Domestic HIV/AIDS Research		
Measure Unique Identifier	**Data Source**	**Data Validation**
2.1.8	Diffusion of Effective Behavioral Interventions (DEBI) Tracking Database	Internal program data are routinely monitored and cross-checked to ensure rapid deployment of DEBI trainings.
2.2.1	Calculations of HIV incidence and prevalence, utilizing HIV/AIDS Incidence Surveillance System and special prevalence studies	CDC will conduct validation and evaluation studies of the methodology and data systems used to calculate HIV transmission rates. Population data come from the Bureau of Census and will be updated annually.
2.2.2	Medical Monitoring Project (MMP)	CDC will conduct validation and evaluation studies of the implementation of data systems that monitor medical care among persons diagnosed with HIV.
2.3.1 – 2.3.2	National HIV Behavior Surveillance (NHBS) System	NHBS is a new surveillance system monitor for monitoring HIV risk behaviors among persons at-risk for HIV infection. NHBS surveillance methodology is being evaluated and fine-tuned throughout its first 6-year cycle.
2.4.1	Special studies using eHARS	CDC conducts validation and evaluation studies of the data systems which monitor HIV/AIDS to determine the quality of data generated by them. The methodology for assessing this measure has been vetted at professional conferences and will be published in a peer-reviewed journal.
2.4.2	Counseling, Testing, and Referral System (CTR) -> Program Evaluation and Monitoring System (PEMS)	CDC evaluates the data systems used to report prevention program activity and develops guidelines for implementation, data entry and program monitoring to determine the quality of data generated by the systems.
2.4.3	eHARS	CDC conducts validation and evaluation studies of the data systems which monitor HIV/AIDS to determine the quality of data generated by them. As of December 2005, 33 states have mature, stable HIV surveillance systems to allow for trend analysis. These states are: Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Iowa, Indiana, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New York, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. The period of time between a diagnosis of HIV or AIDS and the arrival of a case report at CDC is called the "reporting delay". In order to provide the best estimates of recent trends, HIV and AIDS surveillance data are analyzed by date of diagnosis and are statistically adjusted for reporting delays and incomplete information on some cases. CDC requires a minimum of 12 months after the end of a calendar year to provide accurate trend data.
2.5.1 – 2.5.3	Program Evaluation and Monitoring System (PEMS)	CDC evaluates the data systems used to report prevention program activity and develops

HIV/AIDS, Viral Hepatitis, STD, and TB Prevention – Domestic HIV/AIDS Research		
Measure Unique Identifier	**Data Source**	**Data Validation**
		guidelines for implementation, data entry and program monitoring to determine the quality of data generated by them.
2.5.4	Medical Monitoring Project (MMP)	CDC will conduct validation and evaluation studies of the implementation of data systems that monitor medical care among persons diagnosed with HIV.

HIV/AIDS, Viral Hepatitis, STD, and TB Prevention – Viral Hepatitis		
Measure Unique Identifier	**Data Source**	**Data Validation**
2.6.1 – 2.6.2, 2.6.4	The National Notifiable Diseases Surveillance System (NNDSS)	NNDSS data are received from state health departments weekly and are reviewed. Reports are checked and any pre-specified data are verified by contacting the appropriate state health department. All data are once again checked and verified with state health departments at the end of the year.
2.6.3	The National Health and Nutrition Examination Survey (NHANES)	NHANES relies on both passive and active monitoring systems for operational and content-related quality control. Passive quality control uses automated computer procedures for detecting data anomalies. After careful analysis, appropriate activities can be undertaken to resolve any data collection issues. Active quality control relies on examiner feedback to identify and evaluate problems and select remedies. NHANES primarily relies on physical measurements from well-established biomedical procedures.

HIV/AIDS, Viral Hepatitis, STD, and TB Prevention – Sexually Transmitted Diseases		
Measure Unique Identifier	**Data Source**	**Data Validation**
2.7.1	The National Disease and Therapeutic Index (NDTI) (IMS Health)	None provided.
2.7.2	The U.S. Department of Labor, National Job Training Program; CDC, IPP Chlamydia Prevalence Monitoring Project	None provided.
2.7.3	CDC, IPP Chlamydia Prevalence Monitoring Project	None provided.
2.7.4 – 2.7.8	STD Morbidity Surveillance System, CDC	Data from STD Morbidity Surveillance System undergo verification and validation procedures including reports back to project areas concerning quarterly and yearly data, trend information, and percentage unknowns for demographic and clinical fields, edit checks and updates, as well as regular communications via fax, phone and e-mail with project staff.

HIV/AIDS, Viral Hepatitis, STD, and TB Prevention – Tuberculosis		
Measure Unique Identifier	**Data Source**	**Data Validation**
2.8.1 – 2.8.3	The National TB Surveillance System	TB morbidity data and related information submitted via the national TB Surveillance System are entered locally or at the state level into CDC-developed software which contains numerous data validation checks. Data received at CDC are reviewed to confirm their integrity and evaluate completeness. Routine data quality reports are generated to assess data completeness and identify inconsistencies. Data submitted via the national Aggregate Reports for TB Program Evaluation are checked for accuracy and inconsistencies. Problems are resolved by CDC staff working with state and local TB program staff. During regular visits to state, local, and territorial health departments, CDC staff review TB registers and other records and data systems and compare records for verification and accuracy. At the end of each year, data are again reviewed before data and counts are finalized and published.

HIV/AIDS, Viral Hepatitis, STD, and TB Prevention – Tuberculosis		
Measure Unique Identifier	**Data Source**	**Data Validation**
2.8.4	The National TB Surveillance System and the national Aggregate Reports for TB Program Evaluation	TB morbidity data and related information submitted via the national TB Surveillance System are entered locally or at the state level into CDC-developed software which contains numerous data validation checks. Data received at CDC are reviewed to confirm their integrity and evaluate completeness. Routine data quality reports are generated to assess data completeness and identify inconsistencies. Data submitted via the national Aggregate Reports for TB Program Evaluation are checked for accuracy and inconsistencies. Problems are resolved by CDC staff working with state and local TB program staff. During regular visits to state, local, and territorial health departments, CDC staff review TB registers and other records and data systems and compare records for verification and accuracy. At the end of each year, data are again reviewed before data and counts are finalized and published.

Zoonotic, Vector-Borne, and Enteric Diseases – Food Safety		
Measure Unique Identifier	**Data Source**	**Data Validation**
3.E.1	PulseNet USA national databases established and maintained at CDC	Pattern submissions to PulseNet national databases are assessed and reviewed on a daily basis at CDC. Submitters to PulseNet databases are certified for competency before they are given access to the national databases. They are required to complete proficiency testing on an annual basis. Pattern and serotype statistics for all of the PulseNet databases are compiled, verified and reported on a quarterly and annual basis.
3.1.1	FoodNet (The Foodborne Diseases Active Surveillance Network) Data	FoodNet data are transmitted, updated, and reviewed monthly. Incomplete data are reviewed with sites on a monthly basis, as are cross checks comparing local data with national data for data validity. Data are closed out and summarized on an annual cycle to produce preliminary reports, published in MMWR in spring of the following year, and a final report, later that year, once the updated population denominator data are available from the US Bureau of Census.

Preparedness, Detection, and Control of Infectious Diseases – All Other: Antimicrobial Resistance & Patient Safety		
Measure Unique Identifier	**Data Source**	**Data Validation**
4.1.1	National Ambulatory Medical Care Survey (NAMCS), CDC, NCHS; NHAMCS, CDC, NCHS	A 10% quality control sample of survey records was independently keyed and coded.
4.2.1	Before December 2004 - National Nosocomial Infections Surveillance (NNIS) system. After January 2005 - National Healthcare Safety Network (NHSN), which replaced NNIS.	Extensive cross-field edit checks ensure the accuracy of the data, incomplete data cannot be transmitted. Detailed instructions for completion of report forms ensure consistency across sites. Process and quality improvements occur through email updates and annual meetings.

Chronic Disease Prevention, Health Promotion, and Genomics		
Measure Unique Identifier	**Data Source**	**Data Validation**
5.E.1	The Extramural Programs Management Information System (EPMIS), which is an internal system for tracking and managing all types of budget actions.	EPMIS report will be run periodically and results authenticated by Division budget leads at monthly meetings with Center budget execution staff.

Chronic Disease Prevention, Health Promotion, and Genomics – Heart Disease and Stroke		
Measure Unique Identifier	**Data Source**	**Data Validation**
5.4.1	National Vital Statistics System, NCHS	Data are validated by NCHS.
5.4.2 – 4.3	National Health and Nutrition Examination Survey (NHANES)	Data are validated by NCHS.

Chronic Disease Prevention, Health Promotion, and Genomics – Diabetes		
Measure Unique Identifier	**Data Source**	**Data Validation**
5.3.1	US Renal Data System	The USRDS is under the administrative oversight of the National Institutes of Health and the Centers for Medicare and Medicaid Services, whose Steering Committee's responsibilities include data validation.
5.3.2	Behavioral Risk Factor Surveillance System (BRFSS)	BRFSS is a state-based health survey system. Data are submitted to CDC on a monthly basis, where the data undergo rigorous quality checks. CDC also verifies performance through quarterly state reports and periodic site visits.

Chronic Disease Prevention, Health Promotion, and Genomics – School Health		
Measure Unique Identifier	**Data Source**	**Data Validation**
5.6.1 – 5.6.2, 5.6.4	Youth Risk Behavior Surveillance System (YBRSS)	Validity and reliability studies of YRBSS attest to the quality of the data. CDC conducts quality control checks and logical edit checks on each record.
5.6.3	National Health and Nutrition Examination Survey (NHANES)	Data are validated by NCHS.

Chronic Disease Prevention, Health Promotion, and Genomics – Cancer Prevention and Control		
Measure Unique Identifier	**Data Source**	**Data Validation**
5.1.1	National Vital Statistics System, NCHS	Data from the NCHS, a nationally recognized public health information source, undergo statistical computation by the Data Analysis Support Team within CDC's Division of Cancer Prevention and Control to prepare measures based on definitions used within the cancer community.
5.1.2	Behavioral Risk Factor Surveillance System (BRFSS)	BRFSS is a state-based health survey system. Data are submitted to CDC on a monthly basis, where the data undergo rigorous quality checks. CDC also verifies performance through quarterly state reports and periodic site visits.
5.1.3	National Breast and Cervical Cancer Early Detection Program (NBBCEDP) Minimum Data Elements (MDE)	Grantees submit MDEs electronically to a data management contractor, who analyzes data and submits it to CDC. All data have indicators to assess completeness. Data are also assessed against established clinical standards.

Chronic Disease Prevention, Health Promotion, and Genomics – Nutrition, Physical Activity, and Obesity		
Measure Unique Identifier	**Data Source**	**Data Validation**
5.5.1 – 5.5.2	Behavioral Risk Factor Surveillance System (BRFSS)	BRFSS is a state-based health survey system. Data are submitted to CDC on a monthly basis, where the data undergo rigorous data quality checks. CDC also verifies performance through quarterly state reports and periodic site visits.

Chronic Disease Prevention, Health Promotion, and Genomics – Tobacco		
Measure Unique Identifier	**Data Source**	**Data Validation**
5.2.1	National Vital Statistics System, NCHS	Data are validated by NCHS.
5.2.2	USDA, Economic Research Service, Tobacco Outlook Reports (TBS-259 Sep 2005, Table 2)	The USDA Economic Research Service updates Tobacco Outlook Reports twice a year. Data quality checks ensure updated census population estimates are incorporated into per capita consumption estimates.

Birth Defects and Developmental Disabilities, Disability and Health		
Measure Unique Identifier	**Data Source**	**Data Validation**
6.E.1	National Center on Birth Defects and Developmental Disabilities Extramural Program Management Information System (EPMIS)	Staff will use current software to track the number of days from delivery of funding package to actual award of resources to grantee.

Birth Defects and Developmental Disabilities, Disability and Health – Birth Defects and Developmental Disabilities		
Measure Unique Identifier	**Data Source**	**Data Validation**
6.1.1	Metropolitan Atlanta Congenital Defects Program (MACDP) and the Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP)	Data from the CDC-based model birth defects surveillance system are updated annually.
6.1.2	National Birth Defects Prevention Network (NBDPN)	Publications are made possible as a result of analyses of NBDPN pooled data sets.
6.1.3	National Birth Defects Prevention Network (NBDPN)	Data from NBDPN are used to measure rates of spina bifida and anencephaly among Hispanics.
6.1.4	Data are from Project CHOICES, a CDC-funded randomized control trial regarding provider-based interventions for preconceptional women who are at risk for an alcohol-exposed pregnancy.	Results of the randomized control trial (2005 target) published in a peer-reviewed journal.

Birth Defects and Developmental Disabilities, Disability and Health – Human Development and Disability		
Measure Unique Identifier	**Data Source**	**Data Validation**
6.2.2	Data provided by the Division of Human Development and Disability's Child Development Studies Team	Publications are made possible as a result of analyses of *Legacy for Children* data.
6.2.3	Data are from the University of Montana**,** Directors of Speech and Hearing Programs for State Health and Welfare Agencies (DSHPSHWA)	Data obtained from the DSHPSHWA are collected on an annual basis. A survey section is included for states to provide updated data from the previous year. Data are compared at CDC to monitor the quality of data being reported. Additionally, data from the National Center for Health Statistics are used to verify the reported number of live births reported by each EHDI program.
6.2.4	Data are from MD STARnet	CDC verifies the data on an ongoing basis but no less than quarterly by contacting grantees at MD STARnet sites via phone or e-mail or phone to ensure a high level of quality among surveillance sites.

Birth Defects and Developmental Disabilities, Disability and Health – Hereditary Blood Disorders		
Measure Unique Identifier	**Data Source**	**Data Validation**
6.2.1	Data are from the CDC blood safety Universal Data Collection System	For those grantees that participate in electronic form submission, the data are updated in real time. For all others CDC verifies the data quarterly.

Health Statistics		
Measure Unique Identifier	**Data Source**	**Data Validation**
7.E.1	National Health and Nutrition Examination Survey (NHANES), National Vital Statistics System (NVSS), National Health Interview Survey (NHIS) and the National Health Care Survey (NHCS)	Review internal information on end of data collection and release of data for NHANES, NVSS, NHIS and NHCS.
7.1.1	Health Statistics' Board of Scientific Counselors and other independent groups	Targets are under development. NCHS plans to implement a systematic approach and tool for assessing the satisfaction of key data users and policy makers.
7.1.2	*Health, United States*	Improvement and innovation in *Health, United States* can be assessed through four components: a) new charts in the Chartbook; b) new trend tables; c) tables substantially revised; and d) major methodological changes. The published archived volumes can be inspected yearly and compared to their predecessors to measure the continuous improvement and innovation.
7.1.3	CDC/NCHS Website	Internal checks of data.

Health Marketing		
Measure Unique Identifier	**Data Source**	**Data Validation**
9.E.1	Participant and subscriber data from the following CDC products: Morbidity and Mortality Weekly Report, Epi-X, Health Alert Network (HAN), Clinician Registry and the Public Health Training Network	Data figures are validated though the Division of Health Information Dissemination.
9.1.1	Web usage statistics, web user performance statistics and user satisfaction statistics	Staff collects web usage statistics on an on-going basis and monitor improvements over time. User performance and user satisfaction will be measured in user testing and other user research methods (on-line surveys, interviews, etc).
9.2.1	Subscriptions to Epi-X, HAN and partner participation in the National Public Radio Network and other electronic communications systems are monitored and maintained. Downloads and other usage information is captured to assess progress.	Staff uses a variety of automated and manual tracking systems to monitor usage of the various communications systems. Data are reviewed by analysts for accuracy and to determine trends in usage and gaps in services.
9.3.1	The Division of Creative Services will maintain a database of multimedia broadcasts produced and delivered by the division.	The Performance Management Team will review and pull reports as needed.

Environmental Health		
Measure Unique Identifier	**Data Source**	**Data Validation**
10.E.1	National Center for Environmental Health (NCEH)/Agency for Toxic Substances and Disease Registry(ATSDR) Project Profile Database	Project Profile maps NCEH/ATSDR goals/measures and FTE's to budget.
10.1.1 – 10.1.3	Environmental Health Laboratory – data systems	Data systems at Centers for Disease Control and Prevention (CDC)'s Environmental Health Laboratory monitor laboratory performance under Clinical Laboratory Improvement Amendments (CLIA). CDC also conducts quality assurance activities internally to confirm results and ensure their validity.
10.2.1	Grantee reporting	CDC project officers will verify that states are fulfilling the requirements of cooperative agreements through routine monitoring of the grants process.

Environmental Health		
Measure Unique Identifier	**Data Source**	**Data Validation**
10.2.2	NHANES	Increased reporting from laboratories electronically, resulting in fewer errors introduced in data during data entry.
10.2.3	Data system is being developed.	Data validation system is being developed.

Injury Prevention and Control		
Measure Unique Identifier	**Data Source**	**Data Validation**
11.E.1	Office of Program Management and Operations	Verification with NEXT data system.

Injury Prevention and Control – Unintentional Injury Prevention and Control		
Measure Unique Identifier	**Data Source**	**Data Validation**
11.2.1 – 11.2.3	National Vital Statistics System	Data verified through CDC's National Center for Injury Prevention and Control, Office of Statistics and Programming Analysis.

Injury Prevention and Control – Intentional Injury Prevention and Control		
Measure Unique Identifier	**Data Source**	**Data Validation**
11.1.1	National Violent Death Reporting System (NVDRS)	Data verified through CDC's National Center for Injury Prevention and Control, Office of Statistics and Programming Analysis.
11.1.2	Youth Risk Behavior Survey	Data verified through CDC's National Center for Injury Prevention and Control, Office of Statistics and Programming Analysis.

Occupational Safety and Health		
Measure Unique Identifier	**Data Source**	**Data Validation**
12.E.1	IMPAC II, the NIH grant review and administration information system, and NIOSH Office of Extramural Program tracking tools.	Staff members performing award notification utilize delivery and read receipt notifications. Data is reviewed three times each year by program staff, concurrent with each review council round.

Occupational Safety and Health Research		
Measure Unique Identifier	**Data Source**	**Data Validation**
12.1.1	National Academies (NA) direct report to NIOSH	NIOSH has contracted with the NA to complete reviews of at least two NIOSH sector programs annually. Upon completion of the reviews, the NA submits a formal report to NIOSH, which includes a quantitative rating of the program, summary of findings, refined outcome measures and suggestions for future improvement.
12.1.2	NIOSHTIC II database and NIOSH Project Planning and Management (NPPM) system	a) Annually, the Office of the Director develops a report on the number of publications produced by select projects using the NIOSHTIC II database and NPPM system. This report is sent to the Divisions for review, to ensure the accuracy and completion of the information; b) Internal Projects – Projects competing for new NORA funds undergo a formal external peer-review process. The NPPM system is used to identify new projects and peer review is verified by the NIOSH Associate Director for Science. External Projects - All external projects are reviewed through the NIH peer review system. The date and details of the reviews are recorded and reviewed by the NIOSH Office of Extramural Programs.
12.1.3	a and b) NPPM system; c) National prevalence derived from the state-based Adult Blood Lead Epidemiology and Surveillance (ABLES) programs	a and b) Program analysts in each division as well as the Office of the Director review project plans in the NPPM system to assess the use of tracking information in the development and/or completion of projects; c) NIOSH statisticians check ABLES data quarterly. Annually, the data is compiled and reviewed by the data manager using MS Access for validity of dates, ages, repeated tests on the same individual, and for completeness of data on exposure sources. Independently, a NIOSH project officer uses SAS to compare annual frequency distributions with previous years' data to check for unusual patterns, potential misclassification of exposure sources, and other data problems. The data manager and project officer then reconcile any differences in their annual analyses.
12.2.1	NIOSH Office of Extramural Programs training grantee annual progress reports, which include performance data	OEP staff review and verify data with grantees via phone or email contact, as needed.
12.2.2	a) National Electronic Injury Surveillance System (NEISS); b) Census of Fatal Occupational Injuries (CFOI) special research file provided to NIOSH by Bureau of Labor Statistics; c) National	a) The Consumer Product Safety Commission (CPSC) annually visits emergency departments that submit data to NEISS to assess case capture, and review records as they are submitted for completeness and internal consistency. NIOSH receives NEISS data

Occupational Safety and Health Research		
Measure Unique Identifier	**Data Source**	**Data Validation**
	Occupational Respiratory Mortality System (NORMS), an interactive query system designed to generate statistics, charts, and maps relating to mortality from occupationally-related lung diseases.	quarterly and reviews the subset of work-related cases that CPSC provides to ensure the cases meet NIOSH definitions of work-relatedness. NIOSH reviews a sample of cases after coding by a contractor to ensure a high level of accuracy for codes that describe source of injury and event/exposure leading to injury; b) NIOSH receives the special CFOI file annually. To avoid duplication of fatalities in the counts, source documents are matched using the decedent's name and other information. To ensure an accurate count of fatal occupational injuries, the census program requires that for each case, the work relationship (that is, whether a fatality is work related) be substantiated by two or more independent source documents or a source document and a follow-up questionnaire; c) NORMS is based on public-use, multiple cause of death data files obtained annually from the National Center for Health Statistics (NCHS). NCHS performs data quality check to remove invalid codes, verify the coding of certain rare causes of death, and ensure age/cause and sex/cause compatibility. To ensure the accuracy of the NORMS results, NIOSH compares the findings to the NCHS control tables.
12.2.3	a) The Mine Safety and Health Administration (MSHA) and NIOSH data sets that are shared between the agencies - MSHA data is routinely collected as part of the enforcement and compliance requirements, and NIOSH data collected during field investigations, in support of current and future research experiments.; b) See Measure 2b	a) The MSHA data is collected according to the agency's standard rigorous sampling and handling protocols. The validation of NIOSH data is ensured by following the protocols developed during the generation of the research proposals. The proposals are peer-reviewed and include calibration requirements for the measurement and handling of the dust samples, as well as procedures for analyzing the results and ensuring the meaningfulness of the data points; b) See Measure 2b.
12.2.4	NIOSH Customer Satisfaction Survey	The survey is conducted by the NIOSH Education and Information Division, in compliance with the standards of the Data Quality Act.

Global AIDS Program		
Measure Unique Identifier	**Data Source**	**Data Validation**
13.A.1.1 – 13.A.1.4	Country Operational Plans (COPS) database	All USG data are validated by the OGAC Strategic Information team following internal procedures.
13.A.2.1 – 13.A.2.4	GAP Planning and Reporting System and OGAC	All USG data are validated by the OGAC Strategic Information team following internal procedures.

Global Immunization		
Measure Unique Identifier	**Data Source**	**Data Validation**
13.B.E.1	Data will be tracked and analyzed through IRIS, GMIS, UFMS, and ICE systems	The monthly budget update is reviewed for accuracy by the Division's Associate Director for Management and Operations (ADMO). The ADMO monitors appropriate use of funds by category (polio, measles, and global disease detection) and CAN numbers. The ADMO works with the GID Branches to ensure that funds are completely obligated by the end of the fiscal year. The overall budget is reviewed by the Branch Chiefs, Deputy Division Director, and Division Director quarterly.
13.B.3.1	UNICEF provides the number of doses of polio purchased with CDC funding in an annual report that is part of the CDC/UNICEF cooperative agreement.	Case count and surveillance indicators provided weekly by WHO are reviewed and analyzed by the Global Immunization Division.
13.B.3.2	GID tracks SIA operations funds provided by country through WHO and UNICEF. WHO provides a 'cost per child' figure for SIA operational costs for each country. GID uses this data to generate and validate the number of children reached with CDC funds.	Case count and surveillance indicators provided weekly by WHO are reviewed and analyzed by the Global Immunization Division.
13.B.3.3	WHO provides the polio case data generated from reports submitted by countries.	Case count and surveillance indicators provided weekly by WHO are reviewed and analyzed by the Global Immunization Division.
13.B.4.1 – 13.B.4.2	WHO, Pan American Health Organization	A team of WHO epidemiologists and statisticians annually review the estimates using a standardized methodology. This is supplemented with information obtained in national surveillance and program reviews as well as special studies. In addition, WHO works with partners to examine the quality and accuracy of these data.

Leadership and Management – Office of Minority Health and Health Disparities		
Measure Unique Identifier	**Data Source**	**Data Validation**
14.B.1.1	Administrative records identifying the number of interns and fellows	Data quality assurance is measured by review of quarterly and annual program progress reports.
14.B.2.1	Administrative records of the number of cooperative agreements funded and institutions supported	Data quality assurance is measured by review of quarterly and annual program progress reports.
14.B.3.1 – 14.B.3.4	Documented participation and consultation with AI/AN tribes and tribal organizations at regional or national consultation sessions or meetings, official meeting summaries, and TCAC recommendations to CDC leadership, reports from CDC funded projects and documented activities or collaborative efforts, and CDC Financial Management Office tracking of resources allocated to AI/AN tribal programs.	Data quality assurance is measured by review of quarterly TCAC meeting summaries and CDC Annual Tribal Budget and Consultation Report to OS/HHS, and documented outcomes of key program activities.
14.B.4.1 – 14.B.4.2	The number of collaborative efforts, documented activities, and products	Data quality assurance is measured by review of quarterly and annual program progress reports, and documented outcome of key program activities.

Leadership and Management – Public Health Law Program		
Measure Unique Identifier	**Data Source**	**Data Validation**
14.C.1.1	The CDC Public Health Law Program	Documentation of dissemination of the curricula will be provided by the CDC Public Health Law Program.

Public Health Workforce Development		
Measure Unique Identifier	**Data Source**	**Data Validation**
14.D.1.1	Currently, data are based on the number of fellows (EIS, PHPS, PMR) that are core funded.	Staff reviews and validates data through the program's personnel system.
14.D.2.1	Data for the FY 2006 – FY 2008 targets are related to laboratory safety and security. The data are collected following each course, reviewed, and evaluated by a statistician.	Data are reviewed by the CDC Training Advisor responsible for the course. Collective data are checked quarterly.

Buildings and Facilities		
Measure Unique Identifier	**Data Source**	**Data Validation**
15.E.1	CDC-monitored utility meters at Campus or building level, and utility bills	Meters are owned and validated by the utility, and are checked monthly
15.E.2	GSA Rent bills, CDC market surveys, and commercially available data sources such as Black's Guide and CoStar	Market surveys are conducted no less than monthly and verified against GSA and commercially available data that serves as "benchmark" data for private industry.
15.1.1	Project Management Plans and Facility Project Approval Agreements	On-site validation in daily or weekly meetings with Project Managers and Contractors verified against approved project management plans and contractual schedule of deliveries and payments.
15.1.2	Facility Condition Index and periodic employee census counts	Verification or personnel counts with end-users when the buildings come on line, with additional verification through bi-annual building census. Laboratory "standard" verified through periodic (3-5 year) reviews of Facility Condition Index against published CDC laboratory and construction guidelines (Biosafety in Microbiological and Biomedical Laboratories, and CDC Design and Construction Standards).
15.1.3	"The Management System (TMA)" tracking reports	Tracking performed at the work order level through TMA, with monthly verification by operations & maintenance inspection personnel.

Terrorism – Upgrading State and Local Capacity		
Measure Unique Identifier	**Data Source**	**Data Validation**
16.E.1	CDC's Coordinating Office of Terrorism Preparedness and Emergency Response has maintained a management information system on CDC's Secure Data Network (SDN) for approximately three years. This system, known as SLPP-MIS, is used to receive, process, monitor, and evaluate cooperative agreements of over $750 million per year for 62 grantees.	When the technical review process begins, the date/ time will be noted in the system; Once the target date/time is reached, the system will be closed and Project Officers will not be able to conduct additional technical reviews.
16.3.1	The Laboratory Response Network (LRN) delivers accurate and timely identification of agents causing public health treats, including both naturally occurring disease and organisms that could be used in a biologic terrorism attack.	The data collection and validation activities across the LRN significantly enhances the capacity of laboratories to rapidly detect and identify agents likely to be used in a terrorist attack and provide timely information to health professionals.
16.4.1	Epi-X Application, Laboratory Response Network Laboratories, Public Health Emergency Preparedness & Response Cooperative Agreement recipients.	While CDC is developing objective measures that define CDC-compliant, standards-based electonic disease surveillance systems, half of the grantee recipients report use of Internet browser-based data entry and receipt of electronic laboratory results (ELR). Additionally, all LRN Labs use established protocols for telephone reporting and have the ability to usee a spreadsheet mechanism for reporting through the secure website.
16.2.1	HAN, CDC's Division of the Strategic National Stockpile (SNS)	HAN is maintained by the National Center for Public Health Informatics (NCPHI). The data that passes through and is captured in HAN is frequently validated by NCPHI staff.
16.6.2	Completed SNS Assessment Tools, based on criteria outlined in A Guide for Preparedness, V 10.00	The SNS program maintains a staff Program Services Consultants who provide ongoing technical advice and training assistance to Public health Emergency Preparedness & Response grantees. The consultants also assess the grantee's level of preparedness to receive, distribute and dispense SNS assets. These services improve the grantee's ability to receive, stage, store and distribute the SNS material.
16.9.1	Self-reported data as part of required progress reports	See Efficiency Measure Data Validation

Terrorism – Upgrading CDC Capacity		
Measure Unique Identifier	**Data Source**	**Data Validation**
16.E.3	COTPER has been at the forefront of development of two information technology tools for budget and performance integration. These tools are now widely used by a variety of staff for a variety of purposes, including gaining efficiencies in the consolidation of information systems, and reducing the time required to find, collate, and use data.	Health Impact and IRIS B&PI are used to track annual costs for personnel and materials development.
16.3.2	The Laboratory Response Network (LRN) delivers accurate and timely identification of agents causing public health treats, including both naturally occurring disease and organisms that could be used in a biologic terrorism attack.	The data collection and validation activities across the LRN significantly enhances the capacity of laboratories to rapidly detect and identify agents likely to be used in a terrorist attack and provide timely information to health professionals.
16.3.5	Targets Under Development	
16.5.3	Targets Under Development	
16.6.7	Targets Under Development	
16.9.2	Targets Under Development	
16.9.3 – 16.9.4	Self-reported data as part of required progress reports	See Efficiency Measure Data Validation

Terrorism – Biosurveillance		
Measure Unique Identifier	**Data Source**	**Data Validation**
16.E.3	COTPER has been at the forefront of development of two information technology tools for budget and performance integration. These tools are now widely used by a variety of staff for a variety of purposes, including gaining efficiencies in the consolidation of information systems, and reducing the time required to find, collate, and use data.	Health Impact and IRIS B&PI are used to track annual costs for personnel and materials development.
16.2.1	BioSense application tracks the number of members and users of the application in a database. CDC's Epi-X network tracks the number of state and local public health professional that use the system.	The number of members and users will be reviewed on a regular basis. The number of state and local public health professionals who use Epi-X to share intelligence regarding outbreaks and other emerging health events is captured in the Epi-X application. This number is tracked through the registration process of the application. There are automated system controls in place as well as manual procedures that are frequently conducted to validate that the information being collected is accurate.
16.2.2	Targets Under Development	
16.3.3	In addition to specimen and results data, the Health Level 7 (HL7) message utilized for messaging LRN data to the CDC carries information regarding the specific data source. This information will allow us to differentiate between LRN Results Messenger and a local LIMS data. Further development is underway to allow easy reporting on various types of messages from the different sources, allowing us to quickly discern the number of messages related to various programs.	Messages sent to the CDC from external sources must pass through the data broker before being parsed and sent to specific programs within the CDC. The Data and Message Brokering (DMB) team will perform edits to ensure that the message is formatted properly and that we have a Collaboration Protocol Agreement (CPA) with the originating entity. The DMB team will also perform some basic edits to ensure that the message contains all required fields and will also perform validation on the vocabulary included in the message to ensure that message utilizes standard vocabulary sets (LOINC, SNOMED, etc.). In addition, PHINMS reporting will be used to monitor activity, such as the volume of messages received over a predefined period, from the various partners. Additional validation includes periodic review by BPRP and NCPHI resources to ensure data quality and completeness. And finally, data that is shared with other programs such as BioSense and Biological Warning and Incident Characterization (BWIC) will undergo additional validation specific to that system.
16.3.4	Targets Under Development	

Terrorism – Biosurveillance		
Measure Unique Identifier	**Data Source**	**Data Validation**
16.5.1	The Quarantine Station Rating System developed by the Infrastructure workgroup in the Division of Global Migration and Quarantine (DGMQ)	An Excel workbook is the tool that is to be utilized by each of the CDC Quarantine Stations to evaluate their infrastructure and operational readiness. It is comprised of eight sheets that correspond to the tabs at the bottom of the screen in Excel: Staffing; Office Space; Office Equipment; Office Furniture; HIR (Holding/Isolation Room); Office Supplies; Medical Equipment & Supplies; Transportation. Each of these sheets has lists of items and resources (including staff) that one will mark with an "X," "NA" or leave blank to indicate the current status of this resource at the Quarantine Station. The QS Rating System document explains how the system works, and describes the meaning of terms, such as C (critical), N (necessary) NR (needed but not rated), and the Holding/Isolation Room levels - (1,2,3,4).
16.5.2	Targets Under Development	

Terrorism – Strategic National Stockpile		
Measure Unique Identifier	**Data Source**	**Data Validation**
16.E.2	CDC's SNS analysis of product Life Cycle Tools.	CDC's SNS coordinates with the FDA and maintains an internal tracking system for identification of products that may be eligible for the SLEP.
16.6.2	Completed SNS Assessment Tools, based on criteria outlined in A Guide for Preparedness, V 10.00	The SNS program maintains a staff Program Services Consultants who provide ongoing technical advice and training assistance to Public health Emergency Preparedness & Response grantees. The consultants also assess the grantee's level of preparedness to receive, distribute and dispense SNS assets. These services improve the grantee's ability to receive, stage, store and distribute the SNS material.
16.6.3 – 16.6.6	DSNS	DSNS maintains internal tracking systems to monitor its ability to deliver critical medical assets in a national emergency. A new Stockpile Resource Planning (SRP) database and inventory system is used to track and validate stockpiled material.

TARGET VS. ACTUAL PERFORMANCE: PERFORMANCE MEASURES WITH SLIGHT DIFFERENCES

"The performance target for the following measures was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance."

Program	Measure Unique Identifier
Infectious Diseases	
Immunization and Respiratory Diseases – Section 317 Program	1.2.1 (varicella), 1.3.2
Immunization and Respiratory Diseases – Influenza	N/A
HIV/AIDS, Viral Hepatitis, STD, and TB Prevention – Domestic HIV/AIDS Research	N/A
HIV/AIDS, Viral Hepatitis, STD, and TB Prevention – Viral Hepatitis	N/A
HIV/AIDS, Viral Hepatitis, STD, and TB Prevention – Sexually Transmitted Diseases	2.7.3, 2.7.4, 2.7.5, 2.7.6b, 2.7.7, 2.7.8
HIV/AIDS, Viral Hepatitis, STD, and TB Prevention – Tuberculosis	2.8.2
Zoonotic, Vector-Borne, and Enteric Diseases – Food Safety	3.1.1 (E. coli, Listeria)
Preparedness, Detection, and Control of Infectious Diseases – All Other: Antimicrobial Resistance & Patient Safety	N/A
Health Promotion	
Chronic Disease Prevention, Health Promotion, and Genomics – Heart Disease and Stroke	N/A
Chronic Disease Prevention, Health Promotion, and Genomics – Diabetes	N/A
Chronic Disease Prevention, Health Promotion, and Genomics – School Health	N/A
Chronic Disease Prevention, Health Promotion, and Genomics – Cancer Prevention and Control	N/A
Chronic Disease Prevention, Health Promotion, and Genomics – Nutrition, Physical Activity, and Obesity	N/A
Chronic Disease Prevention, Health Promotion, and Genomics – Tobacco	N/A
Birth Defects and Developmental Disabilities, Disability and Health – Birth Defects and Developmental Disabilities	N/A
Birth Defects and Developmental Disabilities, Disability and Health – Human Development and Disability	6.2.3
Health Information and Service	
Health Statistics	7.1.3
Health Marketing	9.E.1
Environmental Health and Injury Prevention	
Injury Prevention and Control	N/A
Injury Prevention and Control – Unintentional Injury Prevention and Control	N/A
Injury Prevention and Control – Intentional Injury Prevention and Control	N/A

Program	Measure Unique Identifier
National Institute of Occupational Safety and Health	
Occupational Safety and Health	10.E.1
Occupational Safety and Health (Research)	10.1.3
Global Health	
Global Health – Global AIDS Program	13.A.2.1, 13.A.2.2
Global Health – Global Immunization	13.B.E.1
Public Health Improvement and Leadership – Office of Minority Health and Health Disparities	14.B.2.1
Public Health Improvement and Leadership – Public Health Workforce Development	14.D.1.1
Buildings and Facilities	N/A
Terrorism	
Upgrading State and Local Capacity	16.6.1a
Upgrading CDC Capacity	N/A
Biosurveillance	N/A
Strategic National Stockpile	16.6.5